Beautiful Mind Therapy, Inc
Phone: 708-695-4808Fax: 888-965-7017
975 East Nerge Road, Suite W40, Roselle, IL 60172-4809

Payment Agreement

A credit card is required to be kept on file for all patients.

Patient Name: _____ Patient DOB: _____

Payment for Psychotherapy Services:
In consideration of the services to be rendered by the clinicians of Beautiful Mind Therapy, Inc (BMT), the undersigned agrees, as patient or guarantor for patient, to pay BMT for all services rendered to the patient 1) at the established rate agreed upon at the time services are rendered or 2) to make payments in accordance with contractual rates between BMT and the patient's insurance company in effect at the time services are rendered. The undersigned will be given at least 30 days advance notice if BMT's fees change.

Payment Authorization
Upon my request, BMT will submit claims to my health insurance company on my behalf for reimbursement of services rendered. I will pay my balance in full at the time of each session in the amount of estimated insurance plan deductibles, co-insurances, co-payments or sliding scale fee. Please initial all that may apply.

____ (please initial here**) I agree to make payments in full by CASH, CHECK, OR ZELLE at time of each session.** Checks should be made payable to Beautiful Mind Therapy, Inc. When paying by check, please write out your check before each session, so our time can be focused on your primary concerns. Zelle payments should be sent to the account of beautifulmindtherapy@gmail.com.

____ (please initial here) **I agree to make payments in full by CREDIT CARD at the time of each session** and have completed the billing information below. I understand that the card provided will only process as a "credit" transaction and a convenience fee of 3.9% will also be applied per transaction.

Unpaid Balance Payment and Credit Card Authorization
If at the time of service or notification of an accrued fee, I do not pay in full, or I have an outstanding balance, I understand my card on file will be charged. I have completed the billing information below.

____ (please initial here) I authorize BMT to utilize my credit card account for payment of any unpaid balances, including deductibles, co-payments, failed appointments, and late cancellation charges, plus a convenience fee of 3.9% per transaction.

I agree and understand:

a. I may terminate treatment or services at any time, but I am responsible for payment of any services rendered to me/the patient prior to termination (please initial here) ____
b. I understand that payment is due either in full or in part at the beginning of each session, as arranged when services are initiated (please initial here) ____
c. I am financially responsible for any late cancellations or "no shows" which occur without twenty-four (24) hours prior notice given to the clinician (please initial here) ____
d. While I may have insurance covering the cost of the treatment, all fees incurred in connection with my/the patient's treatment are my financial responsibility (please initial here) ____
e. I authorize BMT to charge a penalty fee of $25 per incident to cover the bank fee that BMT will incur if my personal check is returned for insufficient funds (please initial here) ____
f. BMT will keep the credit card information provided on file and maintained in accordance with HIPAA (please initial here) ____
g. In the event the matter of unpaid fees is referred by BMT to any agency or attorney for collection, I will be responsible for the payment of all costs of collection, including attorney fees (please initial here) ____

Name as it appears on card (please print): _____ Billing Zip: __ __ __ __ __

Card Number: __ __ __ __ / __ __ __ __ / __ __ __ __ / __ __ __ __ Expiration Date: __ __ / __ __ CVV (3 digit number on the back of your card) : __ __ __

My signature below indicates that I have read and understand this entire PAYMENT AGREEMENT and its terms and agree to the provisions set forth herein.

Patient Name: _____ Patient Signature: _____ Date: _____
(age 18 and older)

Patient Name: _____ Patient Signature: _____ Date: _____
(age 12 and older)

Parent/Guardian Name:_____ Parent/ Signature: _____ Date: _____
(for patient under age of 18) Guardian

Therapist Name: _____ Therapist Signature: _____ Date: _____