Client Financial Agreement

Aspen COUNSELING & Consulting, L.L.C.

Client name: _____

Responsible party name: _____
(if different from client)

- Full payment is due at the time of services. All co-pays, deductibles, and co-insurance must be paid prior to receiving services.
- Please notify the office of any changes to your insurance plan.
- You are responsible for obtaining any required referrals prior to your first visit.
- Failed appointments or appointments cancelled with less than 24 hours advance notice will result in a $75.00 fee.
- All appointment cancellations must be made by phone.
- Aspen Counseling & Consulting LLC reserves the right to suspend services if your account is past due.

You may pay at the time of service or you may store a credit or debit card that will be charged for any amount due.

Please indicate your choice:

☐ **I will pay at the time of service.** I agree to reschedule appointments if I cannot pay the full amount. I understand that future appointments may be cancelled if I fail to make payments at the time services are provided.

☐ **I authorize Aspen Counseling & Consulting, LLC to securely store my credit or debit card information through its electronic processing vendor, Paytrace.** I authorize my credit or debit card to be charged at the time of service for any amounts due. I further authorize Aspen Counseling and Consulting, LLC to charge my credit or debit card for any future services.

Name on card: _____

Address: _____

Credit card number: _____

Expiration date: _____/_____ Security code: _____ Zip code: _____

Cardholder's signature: _____ Date: _____

This authorization is valid for one year from the date signed. You can opt out of auto payments at any time by contacting our office at 815-399-9700.

I accept the terms of this agreement.

Client's /responsible party's signature: _____ Date: _____