THE SIBLEY GROUP

Positive psychotherapy for families, couples & adults

STATEMENT OF FINANCIAL RESPONSIBILITY

I, _____, understand that it is the policy of the practice to retain credit card information from all clients. Payment is expected on the day of the scheduled therapy session and will be charged to the listed credit card, unless a check is provided for payment. Credit cards will be used to charge for missed sessions or for late cancellations unless a check is provided by the end of the business day on the scheduled date of the appointment. By listing the contact information below, I am identifying the person who holds financial responsibility for payment.

AUTHORIZATION FOR CREDIT CARD USE

I authorize Allison Sibley & Associates, PLLC, to use the credit card information that I supply below to charge my credit card for services provided through Allison Sibley & Associates, PLLC, to me and/or my child. I understand and accept that my credit card will be charged on the day of the scheduled appointment, unless a check is provided for payment.

By signing this form, I understand that Allison Sibley & Associates will send monthly statements with detailed information about services, charges, payments, and appropriate information for out-of-network insurance reimbursement, if requested and applicable. By refusing to sign this form, I understand that I must contact Allison Sibley to discuss prepayment for services.

_____

Client Name

_____ _____

Signature Date

_____ _____

Name on Credit Card Credit Card Number
Visa, MasterCard, or Discover

_____ _____

Billing Address (Street, City, Zip Code) Security Code

_____ _____

Expiration Date