PENNY MANNING LCPC

Payment Policies and Procedures

Method of Payment: (please select your preference)

Check Cash Credit card

Insurance Co-Payment/Co-Insurance/Deductible: _____

Cancellation/No Show Policy:
I agree that I will pay $75.00 for all missed appointments and appointments canceled without 24-hour notice

Initials: _____

Credit Card Authorization Request
I authorize Penny Manning to charge my credit card for the following purposes (when applicable):

_____ Co-payments
_____ Onetime payments on an account
_____ Any outstanding balances after date of service
_____ Charges for missed sessions or sessions which are canceled without 24-hour notice

Name on Credit Card: _____

Type of Card: Discover Visa MasterCard

Card #: _____ Expiration Date: _____

Security Code (last 3#s on back of card): _____

I hereby give authorization for payment of insurance benefits to be made directly to Penny Manning for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Client or Authorized Person's Signature: _____

Date: _____