Sheri Bland Solutions Ltd.
2200 Huntington Drive North; Algonquin, IL 60102
Phone: 815-355-1116 FAX: 815-356-7139
Sheribland.sbs@gmail.com SheriBlandSolutions.com

Payment for services Agreement/Credit or Debit Card Authorization

Please be advised of the following terms of our Financial Policy Agreement. **Payment at time of service:** Co-pays, co-insurance and payments towards deducitble and self-pay fees are due at time of service. **Outstanding Bills**: It is not our policy to carry balances with our clients. Balances are due within 2 weeks of billing. **Missed Sessions:** Any missed sessions or cancellations without a 24-hour notice will be charged to your designated credit card at the rate of $125 per occurrence, for loss of income.

For those using a credit/debit card not in their name, we must get the signature of the one the credit card is listed under.

Client Name:_____ DOB: _____

_____Credit or _____Debit Card; Type: (circle one) Visa Master Card Discover HSA/FSA Am Ex

Cardholder Name:_____

Street Address associated with card:_____

City/State/Zip:_____

Credit Card Number:_____

Expiration Date:_____ Security Code:(CVV)_____

OK to E-mail my receipt through Therapy Appointment:_____Yes _____No ____Other(_____)

Choose 1 or 2:

1. ____I agree to the terms above and will authorize you to bill my credit/debit card for copays, payments towards deductible, unpaid balances due and missed/late cancel appointments.

_____ _____
Signature Date

-OR-

2. ____ I elect to not pay with credit card, but will pay co-pay/self- pay fee with check or cash at each session; I will pay balances due for co-insurance or deductible within 2 weeks of notification of balance due.

_____ _____
Signature Date

