



Patient's Financial Responsibilities

I understand that while I am under the care of NVCBT treating staff, payment is due at the time of services provided, and I understand that the financial obligation is my responsibility as the patient. I am responsible for any fees/charges incurred, including those portions not paid for by my insurance carrier or by the provisions or policies of my benefit plan. I further acknowledge and understand that the session fee at NVCBT is approximately \$250.00.

NVCBT accepts Visa, MasterCard, DiscoverCard, money orders, personal checks and cash. All money orders and personal checks should be made out to "NVCBT" or "Nevada Center for Behavior Therapy."

I understand that NVCBT requires I have a credit card on file to prevent large balances from developing. However, I also understand that this credit card will not be used without my permission unless a balance of \$450.00 or higher develops.

NVCBT treating staff will see me at the time scheduled. Because this time is reserved solely for me, I understand that it is important that I keep this appointment. I understand that all appointments must be cancelled within 24 hours of the scheduled appointment time. If I cancel an appointment without 24 hours notice, or if I do not show up for an appointment, I understand that I will be responsible for paying the full cost of the session. I also understand that if I fail to pay for services provided, my account may be referred to a professional collections agency, and reports may be made to the three major credit tracking agencies. Furthermore, I also understand that legal action may be taken to collect unpaid bills and that I will be charged attorney fees and processing fees that result.

I understand the above terms and conditions.

Please sign and date here

Credit Card to Keep on File

Card Type: Visa MasterCard Discover

Card Number: _____

Expiration Date: _____ **Billing Address:** _____

Billing Zip: _____