Brianna Longwell
Mental Health Therapist
MA, Med, LMHC, BCBA, LBA, CRC

Brianna Longwell Psychotherapy
with Associates in Mental Health

103 E Holly Street, Suite 202
Bellingham, WA 98225
(360) 927-9556

PAYMENT AGREEMENT AND CREDIT CARD AUTHORIZATION FORM

GENERAL BILLING PRACTICES:
Associates in Mental Health will conduct all billing concerns (copays, collections, etc.) on behalf of Brianna Longwell Psychotherapy (BLP) **except** for private pay, and no call/no show fees, and cancellations within the 24-hr window prior to the scheduled appointment fees. This form does not reflect Associates in Mental Health's specific billing terms and agreements, only those of BLP.

For general billing, copay, collections, and insurance coverage inquiries you can contact Associates in Mental Health at:
Address: 1155 N State Street, Suite 404
Bellingham, WA 98225
Phone: (360) 715-2488
Fax: (360) 671-1842

24-HR CANCELLATION AND NO CALL/NO SHOW POLICY:
Clients are allotted ONE 24-hr cancellation OR no call/no show (both unrelated to illness) per CALENDAR YEAR without charge. The subsequent last-minute cancellations/no shows will result in a $120 charge per missed session.

Charges for these events will occur:
Cancellation within 24-hrs. of session: $120 billed at time of cancellation.
No Call/No Show: $120 billed next business day of missed appointment.

PRIVATE PAY POLICY:
Standard private pay rate is $120/session. Additional billing will be added per 15-minutes at $30. Payment is due at the end of session.

BRIANNA LONGWELL PSYCHOTHERAPY FEE/ BILLING/ PAYMENT POLICY:
Copays and private payments are due in full at the end of each session in the form of cash, check, and credit/debit card.

Clients can authorize BLP to auto-charge their credit/debit cards following private pay sessions, when appointment has been cancelled within 24-hrs of scheduled session, and/or following a no call/no show. Credit/debit card information is stored securely within HIPAA compliant methods. Clients can opt out of this auto-charge in writing at any point/decline to authorize and will receive an emailed bill instead. If email is unavailable, a paper bill can be mailed to the address on file. Clients are responsible for making sure BLP has the most current contact information to receive their bills in a timely manner and assume all responsibility for additional charges if they have not updated their information.

Outstanding bills/fees will accrue 3% interest every 30-days until paid in full.

PAYMENTS TO ASSOCIATES IN MENTAL HEALTH THROUGH BRIANNA LONGWELL PSYCHOTHERAPY:
For bills/fees sent to clients from Associates in Mental Health (AMH), in which clients are unable to pay via AMH's methods (cash or check), BLP can provide intermediary credit/debit card/online payment support on request of the client. These intermediary pyments to AMH are submitted to AMH on the 15th and last day of every month.

For this intermediary payment service, a 2.5% charge will be added for transactional costs.

I HAVE BEEN PROVIDED WITH A COPY OF, AND UNDERSTAND, BRIANNA LONGWELL'S PAYMENT AGREEMENT INFORMATION.

_____ _____
Signature of Client or Legal Guardian Date

_____
Printed Name of Client or Legal Guardian

_____ _____
Brianna Longwell Signature Date

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Credit Card Authorization Form

I, _____ (Client/Payor Full Name) authorize Brianna Longwell Psychotherapy (BLP) to charge my credit/debit card for the following (Initial all that apply):

_____ Private Pay Session Costs ($140 for intake; $120 for subsequent sessions)

_____ No call/No show and cancelled appointments with less than 24-hrs.' notice ($120 fee following the first missed/cancelled without notice appointment)

_____ Intermediary payments for bills/fees from Associates in Mental Health (AMH) (includes 2.5% transactional fee)

I understand that this authorization is valid until canceled in writing and that Brianna Longwell Psychotherapy (BLP) will automatically charge the above fees on an ongoing basis until cancellation of authorization/termination of therapy services. I authorize BLP to keep my credit card information on file; I understand that though this information is secured in an online protected file, and is unlikely to be tampered with, I acknowledge and agree to assume the risk if the file and credit card information is compromised. I understand that the charges will be applied to my card as outlined on page 1 of BLPs Credit Card Authorization and Payment Agreement Form. Additionally, I agree that the card listed below may be charged by BLP in order to settle any outstanding balances accrued by the above listed payor/client upon termination of therapy services including any materials (ex: books, CDs, reference materials, etc.) that I have not returned within one week of completion of my therapy services. I understand that if a chargeback fee is incurred or a retrieval fee of is incurred that I am responsible for these fees.

_____ (Initial here)

I agree that if I have any concerns or questions regarding charges to my account, or if the charge fails to post to my account, I will contact Brianna Longwell for assistance and/or disclosure. I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with Brianna Longwell in writing and those attempts have failed.

_____ (Initial Here)

Credit Card Information	
Card Type: ☐ Visa ☐ Mastercard	
Cardholder Name (as shown on card):	
Card Number:	CVV/ CVC Code:
Expiration Date (mm/yy):	
Credit Card Billing Zipcode:	
Email for Invoice/ Receipt:	

By signing below, I certify that the above information is true and accurate and that I am an authorized user on the credit card/debit account above. I understand that I am responsible for notifying Brianna Longwell Psychotherapy if my credit/debit card information and contact information for billing purposes needs to be updated. Brianna Longwell Psychotherapy agrees to ONLY charge for fees stated above. I understand that charges will be made using this form and Quickbooks, and not by swiping my card.

_____ _____ _____
Signature of Client/Payor Printed Name of Client/Payor Date

_____ _____
Brianna Longwell Signature Date