CAPITAL INSTITUTE FOR COGNITIVE THERAPY, LLC

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WASHINGTON, DC 20009

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BETHESDA, MD 20814

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PATIENT PAYMENT AGREEMENT

Last Name: _____First: _____ Phone #_____
(Please Print) (Please Print)

- Payment is expected at the time of service. Payment may be made by cash or check at the end of your appointment or you may arrange to have your credit card billed automatically after each session.
- Capital Institute for Cognitive Therapy does not accept insurance. You will be given a statement at the end of each month that you can use to submit for insurance reimbursement. You are responsible for all charges regardless of whether you receive insurance reimbursement.
- If you cannot come to your appointment, please call to cancel or reschedule as soon as possible. In the event you do not come to your appointment and do not give at least 24 hours' notice, the full appointment fee will be billed to your credit card or will be due at your next scheduled appointment.

I have read and understand this **PATIENT PAYMENT AGREEMENT**, and am financially responsible for all charges
.
(Initial) _____I will bring payment by check or cash to each session
(Initial) _____I authorize CICT to automatically bill my credit card after each session or late cancellation. I will call the Business Office at 202-603-4918 to provide my credit card information (in order to protect your privacy, please do not write your credit card number on this form).

Signature: _____ Date: _____

Guarantor Information (complete form below only if the patient is NOT paying the bill):

*Note: You must provide a credit card to CICT if you agree to be the responsible party for the patient's bill. Call the Business Office at 202-603-4918 to provide credit card information (in order to protect your privacy, please do not write your credit card number on this form).

Name of party responsible for bill: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Phone: _____

Guarantor-Financial Responsibility Agreement:

I, the undersigned, am financially responsible for all charges generated for this patient and agree to the terms of the Services Agreement. Office policy requires payment at the time of service. I understand that each session, including late cancellations with less than 24-hour notice, will be charged to my credit card unless the patient brings in a check or cash to pay for that session.

Signature: _____ Date: _____

Patient Authorization:

I, _____, authorize Capital Institute to send billing statements and otherwise communicate with the above listed Guarantor for payment purposes. This does not authorize the release of clinical information.

Signature: _____ Date: _____