

Colorado Therapy Offices LLC,
5485 Conestoga Court #100-H,
Boulder, Colorado 80301
303-332-1324 fax:303-413-1131

Payment in full (if self pay or using my services as an out of network provider) or co-pays/deductibles (if I am an in network provider with your insurance company) is due at time of services.

Your insurance will be billed on your behalf. Any uncovered services, including, but not limited to: copayments, coinsurance, or deductible for scheduled and kept appointments, sessions cancelled without 48-hour notice, telephone consultations, reports prepared outside of appointments and records review.

You will receive a monthly statement for these fees. If you do not remit payment within 30 days of the statement, your credit card will be automatically charged for your balance due.

This agreement shall remain in existence as long as I am a patient of Rene White LPC, CACIII. or until I provide a written retraction of this agreement.

Patient Name:

Card #:

Expiration Date:

Three numbers on back of card:

Card Holder Name

Street address on file with Credit Card account holder

City, State, Zip Code

I _____ agree to allow Rene White LPC, CACIII to keep my credit card on file. In the event of my balance becoming 30 days past due I acknowledge that my credit card will automatically be charged for the balance due and I will receive a receipt of the charges incurred.

Cardholder Signature Date