Christopher Quaglino, LCSW, LCDC

1507 North Street Office 1, Austin, TX 78756

Method of Payment Agreement Form

I have been informed that Chris Quaglino, LCSW, LCDC uses Square for credit card payment processing. **It is my responsibility to ensure that my email and notifications from my credit card companies and from Square only go to me and no other family members**. Also, that **my Credit Card Statements are not able to be viewed by anyone other than myself or persons I deem okay to know I am seeing Chris Quaglino, LCSW, LCDC for services**. Chris Quaglino, LCSW, LCDC will never give out any information about services, or even acknowledge that he is meeting with you to anyone unless you have completed a Release of Information Form giving Chris Quaglino, LCSW, LCDC explicit permission to do so. I acknowledge that I can make payments in cash if I feel my personal information may be compromised by using a check or credit card.

Please indicate all methods of payment you wish to use for your therapy services below:

* I choose to pay at the time of service, by cash or check, $120 per session.
* I choose to use my insurance and allow Chris Quaglino and/or the billing service contractor of his choosing to file my personal health information, as needed, to his billing service and my insurance company. This applies for **BCBS PPO, Medicare and LYRA insurance only**.
* I choose to supply my credit card information and give my permission for Chris Quaglino to charge my credit card for services rendered and missed appointment fees. I can do so by allowing Chris Quaglino, LCSW, LCDC to securely store my financial information on file in his encrypted database for payment ease.

If you desire this option please fill in your information below:

Credit Card Information: VISA MC AMEX DISC Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name on Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit/ Debit Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_\_\_\_ CVC Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLIENT ACKNOWLEDGEMENT

By signing below, the client hereby authorizes Chris Quaglino, LCSW, LCDC to securely store and process the

payment information above for all services rendered.

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Client Name (please print) Client Signature (or authorized representative\*) Date

\* If signed by an individual other than the client, please indicate the relationship between client and their representative:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_