



101 Crawfords Corner Road, Holmdel, NJ 07733
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Payment Agreement for Services

I understand and agree that Light Heart Yoga and Therapy will be providing professional services and I agree to pay fee(s):

I agree that I am responsible for the charges for services provided by Light Heart Yoga and Therapy therapists to me. Although other insurance carriers may make payments on my account, I understand insurance deductibles, co-payments, or full fee for services are due at day and time of services.

I further guarantee that charges for services provided will be paid upon receipt of billing statements from (this therapy/agency) and that the balance will be paid in full unless special arrangements are made for alternative payment scheduling. If such alternative arrangements are made, I guarantee that payment will be made in compliance with those arrangements.

I understand should I not fulfill paying my balance on account, that this balance will be turned over to a collection agency and may affect my credit.

I understand that this office will bill insurance companies and other third party payers, but cannot guarantee such benefits, and is not responsible for collection of such payments.

I agree that if I do not provide Light Heart Yoga and Therapy with notice of cancelling and appointment 24 hours in advance of the scheduled appointment that I am responsible for the payment of that appointment at the posted rate above. I will provide a credit card impression so the credit card can be charged for this and collection fees.

I have read the client's right form and reviewed the fee schedule. In signing this form, I understand my rights as a client and my responsibilities for payment to Light Heart Yoga and Therapy.

Credit Card Information

Please note we keep a credit card on file for no shows or for default in payment.

Credit Card Type: _____ Credit Card Code: _____

Credit Card Number: _____ Exp. Date: _____

Credit Card Name as it appears: _____

Client/Guardian Name:	Signature:
Date:	