SESSION GUARANTEE CONTRACT

Per the signed Fee Agreement contained within the greater Psychological Services Agreement, I authorize Dr. Rich Weisberg, d.b.a. Psychological Solutions, LLC to charge my credit or debit card (whichever is supplied below and copy of same which has been taken in lieu of having the physical card) in the amount of One Hundred Fifty Dollars and No Cents ($150.00) on or about the eleventh (11th) business day after the date of my missed appointment.

I also authorize charges related to any and all fees due on my account that remain unpaid after thirty (30) calendar days from the date printed on any invoice sent to me by Psychological Solutions, LLC related to insurance company charges that remain unpaid by me which the insurance company has deemed me to be responsible for including (but not limited to): co pays, co insurance, unmet deductibles, failure to complete coordination of benefit (COB) forms or if the insurance company deems me as "ineligible" for benefits (i.e., I am not covered). This information is often printed on the insurance company's EOB (Explanation of Benefits) sent to both the provider and the insured patient after the insurance company is billed for the visit.

At no time will this credit card number (without card present to be swiped) be used routinely to pay for my bill. This is ONLY in special circumstances where the patient below has not complied with policy and procedures previously set forth and normal attempts to collect payment in a timely manner described above have failed.

Signature: _____

Printed Name: _____

Name as it Appears on Card: _____

Billing Address *including Zip Code* where Credit Card Bill or Bank Statement is received:

_____

_____

Credit Card: Visa or Mastercard Only (circle one)

Card Type: Debit or Credit (circle one)

Card Number: _____

Expiration Date (format mm/yy): _____

Three Digit Security Code on Back:_____

_____