

Nicki Sindle, LPC-MHSP
2021 21st Ave. South, Ste. 432
Nashville, TN.
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615.498.5453

**To Be Completed for Administrative and Billing Purposes:
(All requested information is REQUIRED to receive further care and/or appointments)**

Person Responsible for Payment: _____

Relation to Patient: _____

Phone Number (Preferably Cell Phone): _____

E-Mail of Person Responsible for Payment: _____

I _____, hereby authorize counseling treatment by Nicki Sindle, LPC-MHSP and agree to assume full responsibility for fees for these services.

Fees include regularly scheduled appointments, telephone calls or text communication lasting more than 3-5 minutes, letters, other paperwork, appointments, missed appointments (per the office policy of 48 hour notification), returned checks, and time spent in collaboration with other health care providers. A current schedule of fees is available upon request.

Should it become necessary, I authorize Nicki Sindle, LPC-MHSP to release and exchange in verbal and/or written form any information necessary for the payment of fees, and/or the provision of my medical care. This may include information related to alcohol or substance abuse. In addition, should it become necessary to need the services of a collection service or an attorney to secure payment, I am aware that I will be responsible for all costs, attorney fees, and other related expenses to the collection effort.

I am aware that payment is due at the time of the appointment. Payment may be in the form of cash or check. Payment may also be in the form of credit card (Visa/ MasterCard/ Discover Card). I am aware that failure to pay at the time of the appointment in the form of cash, check, card will result in my credit card being charged the appropriate amount on the day of the scheduled appointment (Regular Fee + 4% Administrative Fee). Certain fees, such as those incurred from missed appointments, will be automatically charged using the credit card on file. I am aware that the signature below authorizes Nicki Sindle, LPC-MHSP to keep my credit card and signature on file and to use the credit card for the above mentioned charges if necessary or directed to do so. I am aware that this form is valid and I authorize charges as necessary unless I cancel the authorization in written notice to Nicki Sindle, LPC-MHSP.

Credit Card Type (Please Circle): **Visa** **MasterCard** **Discover** **Amer Ex**

Card Holder's Name (As it appears on card): _____

Card Holder's Address (Street/City/State): _____

Zip Code Associated with Card _____

Credit Card Number: _____

Expiration Date: ____/____

3 Digit Code on Back of Card (CVV#): _____

Signature of Card Holder: _____ **Date:** _____

I have read this form completely and I am agreeing to the conditions set forth in this form and within the counseling policies of Nicki Sindle, LPC-MHSP.

Signature: _____ **Date:** _____

(A copy of this Signed Document is to be Considered as Valid as the Original)