WRIGHT WELLNESS

www.wrightwellness.me

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Agreement to Pay for Professional Services

I request that Wright Wellness, PLLC, provide professional services to me or my family member, and I agree to pay the fees (outlined in the Informed Consent handout) for these services at the end of each session or otherwise discussed. I agree that this financial relationship with this provider will continue as long as the provider provides services or until I or my family member inform them that I wish to end it. I or my family member agree to make every effort to discuss my concerns with this provider at least once before stopping services. I agree to pay for services provided to me or my family member up until the time the professional relationship has ended.

I understand that balances such as copays, deductibles, insurance co-share amounts, or appointment charges are invoiced the business day after appointments, then automatically processed to my default payment method overnight. This feature is called *AutoPay* and may be paused if I need to schedule payment for a later date or use a different payment method. If I would like to *pause or opt out of AutoPay* to make a different payment arrangement, I understand that I need to contact Wright Wellness immediately. If I opt out of AutoPay, I agree to make a payment after each session unless otherwise discussed with my provider. I understand that I must still add a credit card to be kept on file securely, even though I am choosing to opt-out of AutoPay. I understand that I may be automatically enrolled in AutoPay if I miss payments until I request to opt-out again or make other payment arrangements, or my services with Wright Wellness may be paused.

I also agree to pay for and authorize Wright Wellness to charge my credit/debit card in full for any late notice/no show fees or any balance that is 30 days overdue on my account (including co-payments, deductibles, other professional services or any amount not covered by my insurance) unless another arrangement has been discussed. I understand that services might be paused until payment is made. If I schedule payments, I understand the amount agreed upon will be processed on or after the date requested. I understand the importance of communication with Wright Wellness regarding my payments, and that I can contact Wright Wellness with any general questions about billing, payment plans, or requesting to opt out of AutoPay by calling or texting our billing manager at *682.226.6327* or emailing *billing@wrightwellness.me*.

I agree by providing my signature below that I am responsible for the charges for services provided by this provider to me or my family member, although other persons or insurance companies may make payments for these services as well.

Name on credit/debit card:_____

Billing Address :_____

Credit Card Number:__ **CCV:** __ __ __ __

Exp. Date __ __ / __ __ **Card Holder's Signature:**_____

_____ _____

Signature of Patient Date