FOUNDATION therapies

www.foundationtherapies.com
651-472-6535

Registration & Billing Information

Client Full Name: _____Date of Birth: _____

Billing Address: _____

Billing City: _____State: _____ Zip: _____

Phone: _____ Ok to leave message? □ Yes □ No

Emergency Contact: _____Phone: _____

Relationship to client: _____

Credit Card Number: _____

☐ MasterCard ☐ Visa ☐ AmEx ☐ Discover Exp. Date _____ CVV: _____

Note: A credit card on file is required for all fee for service accounts.

I hereby give consent to charge my credit card for any outstanding balance such as session fees, late cancel or no show fees.

Cardholder Signature: _____Date: _____

Private Pay Clients: Session Rate: $120 before 4pm / $145 4pm or later
Late cancel (less than 24 hours) or no show fee: full session fee (see above)

I am responsible for payment to Foundation Therapies, Inc. for all services rendered. I acknowledge that I am responsible for payment for provided services as well as late cancel or no show fees. I also understand that if I suspend or terminate my treatment any outstanding balance will be immediately due. I understand that if I default on any payment obligations Foundation Therapies, Inc. reserves the right to forward my information to collections and an additional 30% may be assessed to my account to cover these actions. There will be no obligation to provide continuing services to any client who names Foundation Therapies, Inc. as a creditor in any bankruptcy filing.

Signature: _____ Date: _____