Acknowledgement of Payment

I acknowledge that Dr. Kasper has the right to charge my credit card for copays, late fees/no show fees, and any additional charges that I might accrue, not covered by insurance. A copy of my credit card will be kept on file with Dr. Kasper unless an alternative arrangement has been made. The fees are as followed.

* **Copays and High Deductible** amounts determined by your insurance provider.

* **Late Cancelations and No-Shows:** The appointment time for which you are scheduled is especially for you. As a result, I require a **24-hour notice** for cancelations of therapy appointments for any reason. If you do not provide the appropriate amount of notice of cancelation, I charge the following: Late Cancelation Fee **$60**; No Show Fee **$75**.

* **Preparation of Documents:** Letters and Forms are **$25**/15 minute increment (15- minute minimum).

* **Legal proceedings: $300**/hour (including travel, preparation, and attendance paid in-full prior to the court appearance).

_____ _____

Name on Credit Card Credit Card Number

_____/_____ _____

Expiration Date 3 digit code on back of card

_____ _____

Billing address Billing Zip Code

_____ _____

Signature of paying party Date