Southeast Institute for Group and Family Therapy
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Chapel Hill, NC, 27517
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registrar@seinstitute.com

SEI Payment Policy Credit Card And Debit Card Agreement

Southeast Institute policy is payment is required on the day of service or before. Payment may be made by check, cash or credit card.

Please note that you are responsible for all charges incurred for your treatment or the treatment of those for whom you are responsible.

At ***Southeast Institute***, we require keeping your credit or debit card on file as a convenient method of payment. If an "outstanding balance" is owed, then we will charge your credit card on file.

I, _____ (print name) authorize ***Southeast Institute*** to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐ Amex ☐ Visa ☐ MasterCard ☐ Discover

Credit Card Number: _____

Expiration Date: _____ / _____ / _____

CVV Number (3 Digit Code): _____

Cardholder Name: _____

Signature: _____

Billing Address: _____

City: _____ State: _____ ZIP: _____

I (we), authorize and request Southeast Institute to charge my credit card, indicated above, for balances due for services rendered financial responsibility.

This authorization relates to all payments provided to me by ***Southeast Institute***.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60-day notification to ***Southeast Institute*** in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____

Parent/Guardian Signature (if client is child/teen): _____

Date: _____ / _____ / _____