



**ARCH PSYCHOTHERAPY & WELLNESS**

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**Billing Agreement:**  
**Credit Card Addendum**

I hereby grant my Arch Psychotherapy & Wellness clinician permission to charge my credit card for services provided to me. I understand there will be a 3% convenience fee added when my card is charged. I understand that Arch Psychotherapy & Wellness uses third-party vendors for credit card processing.

I understand that I may choose to use a different method of payment at any time, but if I fail to make payment the credit card provided below will be charged for any balance incurred. I agree to notify Arch Psychotherapy & Wellness if this credit card is revoked or replaced.

Arch Psychotherapy & Wellness agrees to keep this credit card information in a locked cabinet only accessible by Arch Psychotherapy & Wellness clinicians, to charge only for services provided according to agreement of client and clinician, and to abide by the Billing Agreement in effect at time of service.

**Card (Visa, MC, or Discover) Number:** \_\_\_\_\_

**Expiration Date:** \_\_\_\_\_

**Security Code:** \_\_\_\_\_

**Billing Zip Code:** \_\_\_\_\_

\_\_\_\_\_  
Signature of client or payor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Representative of Arch Psychotherapy & Wellness

\_\_\_\_\_  
Date