Boston Evening Therapy Associates, LLC

7 Kent Street
Brookline, MA 02445

(617) 738-1480
bostoneveningtherapy.com

1180 Beacon Street
Brookline, MA 02446

Payments to BETA

DATE OF SERVICE _____ AMOUNT PAID: _____

PATIENT NAME: _____ THERAPIST NAME:_____

Check one:

☐ Credit Card to BETA
☐ Check to BETA ☐ Check to Therapist
☐ Cash to BETA ☐ Cash to Therapist

If Credit Card Payment:

☐ Card Scanned by Therapist
☐ Card not Scanned by Therapist (internet problem - Lori will process)

I agree to report the above payment to SBSC along with my regular billing reports: The above payment should be included in the column entitled “Payments to BETA”.

_____
Therapist Signature

Authorization to Use Credit Card for Psychotherapy Services

I authorize Boston Evening Therapy Associates, LLC (BETA) to charge my credit card for the sole purpose of psychotherapy, consulting or counseling services rendered.

I authorize BETA to use my credit card for the following purposes:

Copayments for Insurance covered visit(s) in the amount of: $_____
Private Pay for psychotherapy/consulting session(s) in amount of: $_____
Missed Appointments with less than 24 hrs notice in the amount of: $_130___

Patient Name (please print) _____

Patient’s Address with Zip Code _____

Credit Card: (circle one) **VISA , MASTERCARD, AMERICAN EXPRESS**

Credit Cd#: _____

Exp. date: _____ 3 digit code: _____

Cardholder’s Name (Please Print) _____

Signed: _____ Date:_____

Therapist Name (Please Print)_____

Signed: _____ Date:_____