COUNSELING AND DIAGNOSTIC
CENTER OF WOODFIELD, LTD.

FINANCIAL AGREEMENT - RECURRING

TO BE COMPLETED BY CLIENT AND/OR THE RESPONSIBLE PARTY

CLIENT NAME: **DATE OF BIRTH:** / /

ADDRESS: **UNIT #, ETC.:**

CITY: **STATE:** **ZIP:**

RESPONSIBLE PARTY NAME: **DATE OF BIRTH:** / /

ADDRESS: **UNIT #, ETC.:**

CITY: **STATE:** **ZIP:**

TO BE COMPLETED BY THE CREDIT / DEBIT CARD HOLDER

CARD HOLDER NAME:

ADDRESS: **UNIT #, ETC.:**

CITY: **STATE:** **ZIP:**

CREDIT CARD #:

EXPIRATION DATE: **TYPE:** AMEX | DISC | VISA | MC |OTHER

- I AUTHORIZE THE COUNSELING AND DIAGNOSTIC CENTER OF WOODFIELD, LTD, TO PROCESS PAYMENTS TO THE CREDIT CARD OFFERED ABOVE.

☐ **FOR ALL CO-PAYMENTS DUE AT THE TIME OF SERVICE.**
THIS IS TO BE PROCESSED THE FOLLOWING BUSINESS DAY BY THE CDCW BILLING DEPARTMENT.

-OR-

☐ **FOR ALL ACCOUNT ACCUMULATIONS DUE AT THE END OF EACH MONTH**
THIS PAYMENT IS TO BE PROCESSED ON THE LAST FRIDAY OF EACH MONTH.

- I AUTHORIZE PAYMENT TO BE PROCESSED THE FOLLOWING BUSINESS DAY AFTER EACH SESSION HELD.
- I UNDERSTAND THIS AGREEMENT WILL REMAIN IN EFFECT UNLESS WRITTEN NOTIFICATION IS RECEIVED BY THE COUNSELING AND DIAGNOSTIC CENTER OF WOODFIELD, LTD, NOTIFYING OF A REQUEST TO TERMINATE THIS RECURRING COPAYMENT AGREEMENT.

CLIENT, RESPONSIBLE PARTY SIGNATURE **DATE**

CARD HOLDER SIGNATURE **DATE**

CLINICIAN SIGNATURE **DATE**

FOR INTERNAL USE ONLY - **ACCOUNT #**											**Processed By:**	

955 N. Plum Grove Road, Suite C, Schaumburg, IL 60173 Ph(847)884-0210, Fax(847)884-7349
www.cdcwoodfield.com