LONG GROVE CENTER FOR
Emotional Health
EXCEPTIONAL CARE
FOR ALL STAGES OF LIFE

Adolescent Anxiety Clinic Card on File Agreement

Please complete the following credit or debit card information.

Name of Clinic Participant: _____

Name on Card: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Type of Card (Visa, Mastercard, Debit, etc.): _____

Card Number: _____

Exp. Date: _____/_____ Security Code: _____

I consent to the Long Grove Center for Emotional Health maintaining my payment information. I hereby agree to the weekly charge of $100 per group, which meets one time per week, regardless of attendance at the Anxiety Clinic (or at a discounted rate of $750 if paid in full by the first group).

Parent/Guardian Signature: _____ Date: _____

Witness: _____ Date: _____