

**KATHY HIGGINS LPC LLC**  
**Kathleen Higgins, MS, MA, LPC, LAC, EMDR, NCC**  
5912 S. Cody St., Suite 302  
Littleton, CO 80123  
**720-663-7702**

**Payment Agreement**

I, \_\_\_\_\_ understand and agree to allow KATHY HIGGINS LPC LLC to charge my credit/debit card for **my required copayment amounts and deductible** per the **CONSENT FOR TREATMENT** signed by me.

I understand and agree that this agreement to charge my debit/credit card also includes **missed session fees, no show fees, report writing fees, and group therapy copays.**

This agreement is effective until one year from this date, or until I revoke this agreement in writing.

Signed:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

Address:

\_\_\_\_\_

Credit Card Number:

Exp. Date:

\_\_\_\_\_

\_\_\_\_\_

Security Code:

Billing Zip Code:

\_\_\_\_\_

\_\_\_\_\_