Therapy & Assessment Center

Dr. Samantha Short, Licensed Psychologist
1422 Caldwell St., Suite P, Conway, AR 72034
501-291-3091
drshort@tac.community
tac.community

PAYMENT AGREEMENT

Client's Name:

Address:

Account Number:

Phone Number:

Total Balance Due:

Date:

As per my conversation with Dr. Samantha Short at Therapy & Assessment Center (TAC) on _____________ (date), I ________________ (client name), agree to pay the following about ____________ per week/month to TAC for mental health services rendered.

The first payment of __________ (amount) is being paid on _________ (date) with subsequent payments to be paid every week/month on the ___________ (day of week or month) until the balance of ___________ (total balance) is paid in full.

Failure to a make payment may result in the limiting of any future services until the payment is received.

We appreciate you,

Dr. Samantha Short, LP

Client Signature_______________________

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