CREDIT CARD AGREEMENT (8/15/20

This authorization is to allow **THE PSYCHOLOGY CENTER, INC** to bill my **credit or debit card** for any client balance not paid or covered by my insurance plan(s). This may include annual deductibles, copay or coinsurance amounts, and charges for missed appointments without 48 hr notice. I also give permission for my card and signature to be kept on file and to be used for current or ongoing treatment sessions including both in-office and telepsych sessions (telephone, online video, etc) if I so chose. **Otherwise I will pay by cash or check at each session.**
I wish to receive a written receipt automatically for any charges made by email at EMAIL: ____
(PRINT VERY CAREFULLY AND CLEARLY PLEASE!!)
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Please use my insurance plan benefits to the fullest extent possible and I assign those insurance benefits to The Psychology Center. I understand that this authorization is valid with an **effective date** of ____________ and for the length of treatment but will **expire** (unless renewed) in 12 mos effective ____________ . Or I can **cancel** this authorization at any time through written notice to the practice after any current unpaid balances have been cleared.

Client/PatientName(s):____
____
Cardholder Name (on the card)__________________________________
Cardholder Street
Address:____
City, State & Zip:____
Tel #____________________________ OK to text ? ___ yes ___ no
Type of card: (circle please) VISA Mastercard AMEX Discover

OVER PLEASE

Credit card agreement (cont'd) -

Card number:____

Expiration Date:_____________

Security Code (CVV on back of card)_________________

Cardholder Signature:___________________________________

Date ____________ (Maximum charge amount $200)

NOTE: If you wish, this credit card authorization may also be used to make regular weekly or monthly payments of an agreed set amount to <u>pay off large or unknown balances</u> of an open-ended or ongoing nature. If you chose this option, please indicate:
I agree to Weekly or Monthly (circle one) payments of
$______________ to The Psychology Center, Inc until my account is cleared.

Signature ____
Date__________________

Info received by – (Doctor or Therapist Name) ____________________________________
Date _________________________

8/15/20