**CREDIT CARD AUTHORIZATION / PAYMENT FORM**

|  |  |
| --- | --- |
| Patient Name: |       |
|  |  |
| Responsible Party if Not Paying by Self: |       |
|  |  |
| Relationship of Responsible Party to Patient: |       |

|  |  |
| --- | --- |
| Date of Birth of Responsible Party (for insurance submission): |       |

|  |  |
| --- | --- |
| *Name on Credit Card:* |       |
|  |  |
| *Type of Credit Card:* |       |
|  |  |  |  |
| *My Credit Card Number is:* |      -      -      -      |
|  |  |  |  |
| *Expiration Date (month/year):* |   /   | *3 Digit Security # on Back of Card:* |     |
|  |  |  |  |
| *Address Card is Listed Under:* |       |
|  |  |  |  |
|       | *Zip Code:* |       |

Please check each item below to acknowledge that you have read and understood our policies before signing:

[ ]  I understand that payment is required at the time of service at the Anxiety & OCD Behavioral Health Center (AOBHC).

[ ]  I understand that I am required to provide up-to-date credit card information to be kept on file at AOBHC. I understand I can use Visa/MasterCard/Discover Card.

[ ]  I authorize the use of my credit card on file to resolve any and all balances in full on my account for all clinical services, missed or forgotten payments, and/or appointments cancelled within 24 hours/no shows as outlined in the Service Agreement Form.

[ ]  I understand that my credit card on file is used as a default means of payment unless I let my therapist know ahead of time that I will be paying by cash, check, or Debit Card. Checks can be made to ‘*Anxiety & OCD Behavioral Health Center’.*

[ ]  I authorize that my credit card will be charged a $35 fee for returned/bounced checks.

[ ]  I understand that late payments may be subject to an additional late payment fee.

[ ]  I understand that ongoing noncompliance with payment terms may incur collections charges if I do not provide timely payment to resolve my balance.

|  |  |
| --- | --- |
| Name:  |       |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Signature:  |  |  | Date: |       |