**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: |  |