**PAYMENT INFORMATION FORM**

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

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

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

[ ]  I understand that payment is required at the time of service

[ ]  I understand that I am required to provide up-to-date credit card (e.g., Visa/Mastercard/ Discover Card/American Express) information to be kept on file

[ ]  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 understand that it is **my responsibility** to understand the benefits of my insurance plan. Even though Anxiety & OCD Behavioral Health Center may check into my benefits prior to starting treatment, it is my responsibility to follow up with my insurance company to clarify the details of my out-of-network outpatient mental health benefits, check the status of my claims, and/or reconcile any discrepancies or problems with my reimbursement.

[ ]  I understand that it is **my responsibility** to verify with my insurance company whether 1 hour or longer appointments (CPT 90837) are available for reimbursement and whether preauthorization is needed for these appointments.

[ ]  I authorize Anxiety & OCD Behavioral Health Center to release my information to my insurance company in order to determine benefits to which I may be entitled.

[ ]  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.

[ ]  **All services are 100% non-refundable.**

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

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