Dear Client/Guarantor:

Child & Family Psychological Services, like many other healthcare offices, has implemented a credit card on file policy. You are asked for a credit card number at the time of your first appointment. It can only be a credit card, NOT A DEBIT CARD that requires a PIN. Cards must be run as credit. The information will be held securely to be used to pay balances on your account, such as deductibles, copays, insurance rejections and no show/late cancellation fees. Payment is due at the time services are rendered.

This will be an advantage to you, since you will no longer have to remember to bring your payment with you at each session. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and mail. This will be a benefit to everyone in helping to keep the cost of healthcare down.

This in no way will compromise your ability to dispute a charge or question your insurance company regarding how they processed your claim.

If you choose not to participate, you must maintain a zero account balance. If you make a payment with cash, debit or check on the day of your appointment your credit card will not be charged. All insurance rejections and no show/late cancellation fees will be charged to your credit card within 30 days if you have an unpaid balance on the account.

If you have any questions, please do not hesitate to speak with the billing office. We are working diligently to be stewards of all resources and attempting to keep your costs to a minimum.

Sincerely,
CHILD & FAMILY PSYCHOLOGICAL SERVICES

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Client Name: _____ Date: _____

Date of Birth: _____ Case Number: _____ **(for office use only)**

Name of the Person who is Responsible for Payment: _____

Relationship to Client: _____

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☐ I AUTHORIZE Child & Family Psychological Services to charge outstanding balances on my account to the following credit card: ☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMER EXPRESS

Account Number: _____ Exp Date: _____

Security Code: _____

Name on Card (please print): _____

Billing Address: _____

City/State/Zipcode: _____

Signature: Date: _____

Witness: _____ Date: _____

☐ Please send me a credit card receipt when my credit card has been charged.

☐ I DO NOT authorize Child & Family Psychological Services to charge my credit card. I understand that payment must be made in full at each session and that I must maintain a zero balance on the account.