Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_             DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Co-payments/Self payments are due at time of service.

• Insurance policies are contracts between you & your insurance company. I file these claims as a courtesy and try to help with problems, but you need to resolve those beyond my control. If insurance is not paying within a reasonable time, you will be responsible for full payment.

• If I am not covered by your insurance company, full payment is due when services are provided.

• Any phone conversation over 5 minutes will be charged at a prorated fee based on $100/ hour. This is not covered by your insurance company.

• Any appointments scheduled but not kept, as well as any appointments cancelled within 24 hours of scheduled time will be charged at the rate of $60. This is not covered by your insurance company.

Name on Credit Card:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address of the Credit Card:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number of Cardholder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Security Code/ CVV:\_\_\_\_\_\_\_\_

• I authorize Beth Miller, LCSW to charge my card for office charges.

• I understand that if my credit card does not accept the charge, I will immediately make the payment to the practice.

• I understand that I may cancel this authorization at any time, but by doing so, I acknowledge that the balance owing will be due and paid in full.

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Signature of Cardholder Date