

CREDIT CARD ON FILE POLICY

At Olney Counseling Center we give you the option of keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable.

I (we), the undersigned, authorize and request Olney Counseling Center to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by Olney Counseling Center.

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to [practice name] in writing and the account must be in good standing.

You are giving Olney Counseling Center permission to automatically charge your credit card on file for your outstanding balances or any other patient(s) balances you have listed on this form at time of service.

Co-pays: Co-pays are due at time of the office visit.

Outstanding Balance: If your insurance provider has paid their portion of your bill or any other patient(s) you have listed on this form and there is still an outstanding balance owed, and the balance owed is not paid within 30 days Olney Psychiatric & Counseling Center, will charge the balance to your credit card. A copy of the charge will be mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

This credit card on file is to be used for the following patient(s), please print name(s) below: (expires after 1 year)

Patient Full Name: _____ DOB: ____ / ____ / ____

Patient Full Name: _____ DOB: ____ / ____ / ____

Patient Full Name: _____ DOB: ____ / ____ / ____

Multiple Users: This card will only be authorized for the use of the credit card holder, his/her minor(s), or any person(s) listed above. This agreement will expire for multiple users on an annual basis. If continued authorization is requested, another credit card agreement can be issued or a manager can verbally authorize and document the extension of an agreement.

Signature: _____ **Date:** _____

I authorize Olney Counseling Center to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

Amex Visa Mastercard Discover

Credit Card Number _____

Expiration Date ____ / ____ / ____ **CVV** _____

Cardholder Name _____

Signature _____

Billing Address _____

City _____ **State** _____ **Zip** _____

Date: ____ / ____ / ____