CREDIT CARD INFORMATION

THERAPIST NAME: _____

PATIENT NAME: _____ DOB: _____

TYPE (circle one): VISA MC

CREDIT CARD # _____ EXP: _____

NAME ON CARD: _____ SECURITY CODE: _____

MAILING ADDRESS ASSOCIATED WITH CARD

_____

Street or PO Box City Zip

*I authorize the above named therapist to run my credit card listed above for any balance I accrue after my insurance has processed my claims. I understand that my card will be run without prior notice to myself, unless otherwise specified above and that a receipt will be provided via email. If I wish to terminate my credit card payment on file, I understand that I will need to give five (5) business days notice for this to take effect.

_____ _____

Patient or Guardian Signature (if patient is under 18 years of age) Date

Email address to send credit card receipt:
_____

CREDIT CARD & BILLING POLICIES

Wendy Naiman, LMFT, PLLC requests that all clients to provide a debit or credit card to keep on file in our secure electronic medical records program. My biller, Cascade Therapy Billing, LLC, will charge your credit card for your copay or fee owed following your date of service and will collect coinsurance and deductible payments from the card on file at the time your insurance responds to our claim and has determined the exact portion owed by the client. Clients are responsible for tracking this claim and the amount due by carefully reviewing the Explanation of Benefits (EOB) mailed directly to the client by the insurance company. Clients will receive a monthly statement via email.

Clients without a credit card on file will receive a bill via paper mail and will be subject to a $10 paper billing fee. Clients have a right to receive a statement of all charges, payments and balances associated with their account. A client who wishes to change their credit card on file may do by notifying their therapist to request a form to update the credit card number on file. A client who wishes to cancel a card on file must do so in writing, 5 business days prior to the date on which they wish the change to take effect.

BY SIGNING BELOW YOU AGREE TO THE FOLLOWING: My signature below indicates that I understand and agree to pay for therapy as outlined in this agreement.

_____

Patient or Parent/ Legal Guardian Signature Printed Name Date