therapist name

Automatic Payment Form

If it would be more convenient for us to automatically charge your credit card for each visit, please fill this out.

Patient: _____

I, _____, hereby authorize psychological services from *therapist name* and agree to assume full responsibility for fees for these professional services.

Fees include regular scheduled appointments, telehealth services, phone calls lasting more than five minutes, letters, other paperwork, obtaining of insurance preauthorization, missed appointments (patients are charged for missed sessions in absence of 24 hour advance notification of cancellation), returned checks, and time spent in collaboration with other health care providers or individuals within the circle of care.

I am aware that payment is due at the time of the appointment. I am aware that failure to pay at the time of the appointment in the form of cash or check will result in my credit card being charged the appropriate amount. Certain fees, such as those incurred from missed appointments and phone calls, will be automatically charged using the credit card on file. I am aware that the signature below authorizes *therapist name* to keep my credit card and signature on file and to use the credit card for the above mentioned charges if necessary or directed to do so. I authorize charges as necessary unless I cancel the authorization in written notice to *therapist name*.

Card Holder's Name (As it appears on card): _____

Card Holder's Address (Street/ City/ State/ Zip): _____

Credit Card No: _____ Visa MasterCard Discover AmEx

Expiration Date: _____/_____ 3 Digit Code on Back of Card (CVA#) :_____

Signature of Card Holder: _____ Date: _____

Credit Card Receipt Preference: e-mail to _____ OR text cell phone # _____

Should it become necessary, I authorize *therapist name* to release and exchange in verbal and/or written form any information necessary for the payment of fees, and/or the provision of my medical care. Should it become necessary to need the services of a collection service or an attorney to secure payment, I am aware that I will be responsible for all costs, attorney fees, and other related expenses to the collection effort.

I have read this agreement completely and I agree to the conditions set forth in this agreement and within the Practice Policies of the office of *therapist name.*

Signature: _____ Date: _____

(A Copy of this Signed Document is to be Considered as Valid as the Original)

Modifications: _____