DONARSKI CENTER for MENTAL HEALTH COUNSELING

Credit Card Authorization Form

Client Name: _____

Person Responsible for bill: _____

Receipts will be sent to (Email): _____

Credit/Debit/HSA Card Information

Name Shown on Card: _____

Card Number: _____

Expiration: _____ Security Code: _____ Billing Zip Code: _____

By listing information and signing this agreement, I authorize payments from my credit/debit/HSA/FSA card to Donarski Center for Mental Health Counseling (DCMHC) for the client listed above. I agree upon and understand that no prior-notification will be given before each charge as it is noted here for my records to refer to. If I need to change the card information or payment dates, I will notify DCMHC.

☐ **Copays & Coinsurance Payments at Appointment:** I _____ authorize DCMHC to charge the listed card the amount of $_____ within 7 days of an appointment. Additionally, I authorize DCMHC to charge $85.00 no-show fees to the listed card for a scheduled appointment that was not attended/canceled/rescheduled prior to the appointment time. (Refer to Intake Form for No-Show fee agreement).

☐ **Coinsurance Payments after Insurance Processing:** I _____ authorize DCMHC to charge the listed card for the patient's portion of session fees per the client's health insurance policy (checkmark below to choose a billing schedule)

- ☐ Account balance on the first Friday of each month
- ☐ Account balance on the first and third Friday of each month

☐ **Payment Plan Payments:** I _____ authorize DCMHC to charge the listed card as a recurring payment (checkmark below to choose the appropriate billing schedule), until the balance has been paid in full.

- ☐ $_____ on the first Friday of each month
- ☐ $_____ on the first and third Friday of each month
- ☐ $_____ on the 1st and 15th of each month (if the 1st/15th fall on a non-work-day, payment will be processed on the next workday)
- ☐ Account balance on the first Friday of each month
- ☐ Other: _____

By listing information and signing this agreement, I authorize DCMHC to send receipts via email message and I authorize DCMHC to leave detailed messages with the email and/or phone number listed about a payment plan and balance. I know that I am under no obligation to authorize DCMHC to send me emails. I may opt out of receiving these communications at any time by calling the office.

Signature _____ **Date** _____

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