Psychological Associates, Inc.

CREDIT CARD PRE-AUTHORIZATION AGGREEMENT

Patient/Responsible Party Financial Responsibilities: DEDUCTIBLES, CO-PAYS, AND CO-INSURANCES ARE DUE IN FULL AT THE TIME OF SERVICE. At the beginning of treatment, we request you secure your account with a credit card. This card will only be charged with your permission. We offer two options for charging the patient responsibility relating to your treatment. As a courtesy to you, we can automatically charge your card the estimated patient responsibility for each visit based on the quoted benefits from your insurance company throughout your treatment. Once your claims have been processed, the Explanation of Benefits from your insurance company will determine the patient responsibility and any necessary changes to the amount due will be made.

Additionally, we will use the credit card to process any late cancellation or no-show fees that you have incurred. A receipt will be provided for any charges processed by Psychological Associates, Inc., at your request. If you prefer to bring in payment at every appointment, we will only use your credit card to charge any remaining fees at the end of your treatment, once all claims have been processed by your insurance company.

Please check one: □ Visa □ MasterCard □ Discover □ Amex (Debit cards can be used if they have a major credit card logo.)

Patient's Name: _____

Responsible Party/Cardholder Name: _____

Responsible Party/Cardholder Driver's License #_____State_____

Email Address _____

Acct# _____Exp Date_____ Security Code (on back of card) _____

Billing Address: _____

City, State, ZIP Code: _____

Do you require an itemized/HSA receipt? _____ Dollar Amount to be charged: _____

Please initial the option you prefer:

_____ I will pay the estimated amount due per session at each appointment and will have my credit card on file available only for any remaining balance I owe once my treatment has ended.

_____ I agree to allow Psychological Associates, Inc. to charge my credit card on file for the amount due at each appointment and for any remaining balance I owe once my treatment has ended.

I have read this Financial Policy and I agree to the terms and conditions outlined within this policy. I hereby consent to treatment as deemed necessary and proper by the staff of Psychological Associates, Inc. This form will be kept on file and will remain in effect until the expiration of the credit card account. Applicants may also revoke this form by submitting a written request to the address below. A new form must be submitted if information such as the list of authorized users and the credit card account's expiration date is amended. The applicant must also submit a written notification to Psychological Associates, Inc. if the credit card is cancelled, lost, or stolen. Furthermore, I agree to assign all health insurance benefits directly to Psychological Associates, Inc. and understand that I am responsible for any costs not covered by my health insurance.

Patient/Responsible Party Signature: _____ Date: _____

Additional Cardholder Signature: _____ Date: _____