<u>***Associates in Family Care, 7602 Slate Ridge Blvd., Reynoldsburg, OH 43068***</u>

AUTHORIZATION FOR CREDIT/DEBIT CARD PAYMENT FOR SERVICES

I, ________________________________ authorize Associates in Family Care to charge my credit/debit card for services rendered to myself and/or the clients listed below. <u>In providing us with your credit/debit card, you are giving ***Associates in Family Care*** permission to automatically charge your card on file for the following fees and balance(s) for you and/or other clients listed on this form at the time of service.</u>

Co-pay/Co-insurance/Deductible: The amount defined by the client's insurance company for behavioral health services that are due at the time services are rendered.

Self-Pay Fees: The clinician's fee for service when insurance and/or employee assistance programs do not apply.

No Show and Late Cancellation Fees: The fee of $65 for appointment no-shows or non-emergency cancellations without 24 hour notice.

Outstanding Balance: If the client's insurance provider has paid their portion of the bill and there is still an outstanding balance owed, <u>***Associates in Family Care***</u> will send a balance statement to the client/guarantor/responsible party's address on file by regular mail and/or provide the client with a statement in session. If we do not receive a response or payment in full within **30 days** of the statement date, any balance owed will be charged to this credit/debit card. A copy of the charge will be mailed to you. This in no way compromises your ability to dispute a charge or question the insurance company's determination of payment.

<u>**Any questions regarding payments made, can be directed to Larry Castle in our billing department. He can be reached at 614-771-1778 ext 201**</u>

I authorize AFC to charge the above fees and outstanding balance(s) to my credit/debit card**:**
Visa ____ **MasterCard _____** **Discove**r **____** **American Express ____**

Credit Card# ____ Exp. Date: _____/_____

Security Code: ___________ Card Holder's Name (please print):_________________________________

Signature: ______________________________________ Date: _____/______/______

Zip Code of the card holder:_________________

If you wish to leave this credit/debit card on file for other clients, please print the name(s) below:

Client Name: _______________________________________ Date of Birth: ____/_____/_____

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