Old Towne Counseling Services

Credit Card on File Agreement

We have implemented a policy which enables you to maintain your credit card information securely on file with Old Towne Counseling Services (OTCS). **In providing us with your credit card information, you are giving OTCS, permission to automatically charge your credit card on file for your (or any other patient(s) you have listed on this form): co-pays, co-insurance, outstanding balances and services.**

Co-Pays | Co-Insurance: Co-pays and co-insurances are due at the time of the scheduled office visit. You may still choose to make your payment by check, cash or a different credit card (different from the credit card on file).

Outstanding Balances: If any outstanding account balances are owed, OTCS will notify you via email or by US Postal Service. If the account balance is not paid in full within 5 business days of the mailing of this notice, at that time, any balance owed will be charged to your credit card. For your convenience, a copy of the charge will be mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment. Missed appointment and or late cancel fees, and other non-insurance billable fees will be charged at the time of the missed appointment or fee assessment, and a receipt will be mailed to you.

Services and Products: Self-pay services and other fees are due at the time of scheduled office visit.

VISA MASTER CARD DISCOVER AM EXPRESS

Name: _____

Credit Card #: _____ - _____ - _____ - _____

Expiration Date: _____/_____

Billing Address: _____

_____

Zip Code: _____

CCV# (On back of card): _____

(CARDHOLDER INFORMATION ONLY!!!)

***This card will only be authorized for the use of the credit card holder and or any person(s) listed below by the credit card holder. **This agreement will expire upon termination of service and settlement of final balance.** The card holder may not be available if an unpaid balance accrues.

Please fill out the information below for any person(s) you authorize this credit card for:
IF NO OTHERS ALLOWED, strike through and initial.

Patients Full Name: _____ **DOB:** ___/___/_____

Patients Full Name: _____ **DOB:** ___/___/_____

Patients Full Name: _____ **DOB:** ___/___/_____

Credit Card Holder Signature: _____ **DATE:** ___/___/_____