
CHARIS Counseling Associates
Credit Card on File Billing Authorization Form

We have implemented a policy which enables you to maintain your credit card information securely on file with CHARIS Counseling Associates. In providing your credit card information, you are giving CHARIS permission to automatically charge your credit card on file for your [and/or any client(s) you have listed on this form] co-pays, outstanding balances, late cancellations, no-shows, and/or services.

Please initial below:

_____ I understand that I am not required to sign this agreement in order to receive services. I may choose other means to make payments like cash, bank checks, or having my credit card information entered at time of each service.

_____ Session fees OR Copays are due at the time of the office visit. When using a credit card on file agreement, session fees and copays will be billed for services that week and any previous unpaid session fees or copays.

_____ Outstanding Balance: If you have an outstanding balance owed, CHARIS will notify you at the next session, via phone, mail and/or some other manner. If by the second billing notice from CHARIS, we do not receive a response from you or your payment in full, any balance owed will be charged to your credit card. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

_____ Late Cancellations and No-shows: We understand that things happen and sometimes you can't appear for your scheduled appointment. In that case, please provide 24 hour notice, as our providers set aside valuable time just for you. In the event of a late-cancellation (less than 24 hours) or no-show, we will charge your credit card for the full Standard Rate (full fee before any discounts or write-offs) of the appointment.

This card will only be authorized for the use of the credit card holder or any person(s) listed below by the credit card holder. This agreement will expire on the expiration date of the credit card and/or on the completion of treatment and the payment of all outstanding balances. The card holder may also revoke this consent at any time in writing.

Your credit card information is kept confidential and secure on our online electronic HIPAA compliant record keeping system TherapyNotes, but there are other risks you should be aware of that CHARIS does not control. These risks include, but are not limited to: your card notification indicating that CHARIS, card processing companies, banks, etc., making a charge to your account; retaining CHARIS and your contact information; and/or your personal computer, electronic devices, or programs maintaining records of your contacts with CHARIS. Once your credit card is charged, CHARIS has no control who is able to access that information. The charge information/notification may appear immediately or be delayed from hours to days. There may be fees beyond CHARIS' charge like those from banks or processing companies associated with processing your electronic payment.

I understand that I remain fully responsible for all financial obligations, regardless of plan or method of payment. I hereby authorize the release of my credit card information necessary to process payment. I also grant permission to CHARIS Counseling Associates to charge my credit card in the future without me having to sign this authorization each visit. I understand that CHARIS Counseling Associates may use a collection agency and/or legal action to facilitate the recovery on any unpaid balance. I acknowledge that I have been provided information regarding office billing and credit card policies including fees, missed appointments, late cancellations, the right to refuse treatment, the right to use alternative payment means. I have provided current contact information for CHARIS to communicate with me about the bill. I will update my contact information when it changes.

Please fill out the information below for any client(s) you authorize this credit card payments for:

Client: _____ DOB: ___/___/___ Client: _____ DOB: ___/___/___

Dated this _____ day of _____, _____.

Signed: _____ DOB: ___/___/___

Client/Responsible Party for Billing