CLINICAL CARE CONSULTANTS

AUTHORIZATION AGREEMENT FOR PAYMENT OF YOUR BILL

This authorization is for the patient responsibility portion of your bill. This authorizes Clinical Care Consultants to charge your debit/credit card your co-pay, co-insurance, any session fees if you have an unmet deductible as well as any outstanding balance on your account.
We acknowledge that the origination of transactions to your account must comply with the provisions of U.S. law.

Client Name _____
(Please Print)

Cardholder's Name _____
(If different from client)

Credit Card # _____

Expiration Date _____ **Security Code** _____
Mo/Yr Digits In Code

Cardholder Street Address_____ **Cardholder Zip Code**_____

(Circle One) Master Card Visa Discover

I authorize Clinical Care Consultants to keep my signature on file and to charge the debit/credit card identified above for the balance of charges not paid by my insurance company 60 days or more following date of service and for charges due to No Shows or Late Cancellations. This is for all treatment provided for the above named client.

*** No debit/credit charge will be made until 60 days or more following date of service for the balance of charges not paid by my insurance company, unless credit card payment arrangements are otherwise made and agreed upon between you and your therapist.**

I will be notified by billing staff or statement of any charges made to my debit/credit card.

At any time, I may elect to pay my account in full to prevent this authorization from being activated.

I assign my insurance benefits to Clinical Care Consultants. I understand that I am financially responsible to Clinical Care Consultants for charges not covered by this agreement. I understand that this form is valid unless I cancel the authorization through written notice to Clinical Care Consultants.

CARDHOLDER SIGNATURE (If different from client) Date

CLIENT SIGNATURE (legal guardian signature if under 18) Date