Credit/Debit Card Payment Record

Name As It Appears on Card: _____

Visa: ___ MasterCard: ___ Card Number: _____ - _____ - _____ - _____

Expiration Date: ___/_____ Billing Zip Code: _____ Security Code: _____

I/we authorize Dr. Abrams/Ascension Behavioral Health LLC, to bill the above credit / debit card for professional services as outlined in the Policies. I understand the billing statement will be recorded as “Ascension Behavioral Health LLC.” I will notify Dr. Abrams in writing if I no longer want my credit / debit card billed.

_____ _____

Signature of cardholder Date

Credit Card Payment for Late Cancellation or No-Show

I authorize Ascension Behavioral Health, LLC to charge the above credit card when the client does not give advance notice for a late-cancellation or no-show, as per the Policies. I understand that if I do not want my credit card billed for this purpose, I am still responsible for these fees and will be billed accordingly. I am financially responsible for all charges generated for this patient. Office policy requires payment at the time of service. I understand that unpaid balances over 30 days past due may carry a late fee equivalent to 1.5% per month of that outstanding balance. I understand that unpaid balances over 90 days past due will be referred to a collection agency.

_____ _____

Signature of cardholder Date

GUARANTOR INFORMATION: (complete only if the client is NOT paying for the bill)

Name of party responsible for bill: _____

Address: _____

Date of Birth: ____\ _____ \ _____ Best Phone: _____

Client Signature:

_____

Signature indicates that you agree to allow your therapist to make charges on your card without you present.