SET UP RECURRING PAYMENTS

FILL OUT AN AUTOPAY FORM TO ENROLL

- **Please see the back for instructions and policy**
- **Use debit, credit, or HSA card**
- **Copays, coinsurance, deductibles, etc. will be charged for you.**
- **Need to set up a payment plan? Ask to speak with Billing**

309-692-7755 or home@christianpsychological.org

JOHN R DAY & ASSOCIATES, LTD
CHRISTIAN PSYCHOLOGICAL ASSOCIATES

AUTOPAY AUTHORIZATION

I, (Full Name) _____ authorize John R. Day & Associates to charge my credit/debit card for my visits according to the established fee for counseling/therapy or psychological testing if any. (Psychological testing fees will be discussed separately if needed.)

ACCOUNT #: _____ EXP: _____SEC. CODE: _____

TYPE OF CARD: _____DEBIT _____CREDIT _____HSA SIGNATURE: _____

CARD HOLDER CONTACT PHONE NUMBER: _____

PATIENT NAME (if different from card carrier): _____

**You may cancel this agreement at any time in writing.*
***Due to the sensitive nature of this information, you may bring it to the office, mail it, or call in this information over the phone.*

AUTOPAY POLICY

1. This authorization will be used for all balances, including copays, coinsurance, and deductibles.
2. Copays will be charged after the visit.
3. Deductibles and coinsurance will be charged after insurance replies.
4. If there is psychological testing, the Report Fee will be charged to this card. The balance after insurance will also be charged to this card.
5. For Cash Only clients, the established fee will be charged to this card.
6. For Payment Plans, the agreed amount will be charged to this card.
7. If you would like to use another method of payment, you can let us know at any time.
8. If the card on file is rejected, another method of payment must be provided as soon as possible. If you do not provide us with another method of payment by the next visit, the appointment may be rescheduled.
9. Questions: call 309-692-7755 or email home@christianpsychological.org