ALASE Center for Enrichment II

Helping to Heal Minds, Hearts and Souls

Dear valued client:

Alase Center for Enrichment requests all clients to maintain a credit card on file to cover the cost of co-pays, co-insurance, self-pay, deductibles, no show fees ($50.00) and any other monies owed for services provided. Please fill out the included form. By filling out the form, you agree to have your credit card charged for the above. All credit card information will be kept confidential and safe. Your credit card will be billed for the session and for any and all monies owed to Alase per your Explanation of Benefits (EOB) from your insurance company(s). After your credit card is billed, you will be emailed a receipt within 48 hours.

Sincerely,

Dr. Anthony J. Smith
Executive Director / Psychologist

Credit Cards on File will be used for:

Copays/Deductibles/Outstanding Balances – When services are rendered, you will have the option to use the credit card on file or if at any time you want to use another form of payment, please notify the front office. This authorization will remain in effect until you notify Alase Center for Enrichment in writing of any changes to your account information and/or termination of this authorization.

Missed Appointments – If you miss more than one appointment without calling 48 hours in advance, it is Alase Center for Enrichment's policy to charge the missed appointment fee of $50.00 which is not covered by insurance and cannot be submitted to your insurance carrier.

All patient responsibility amounts, as determined by insurance, will be reviewed by Alase Center for Enrichment's billing department to ensure your claim has been properly processed. Members typically receive their explanation of benefits prior to the provider,

so, if you disagree with the patient responsibility amount owed, it is your responsibility to contact your insurance carrier immediately.

If at any time the credit card on file expires or otherwise becomes uncollectable, we will expect you to promptly provide a new means of payment. If one is not provided, you are still responsible for bill payment in full on the day of service.

We do our best to verify your benefits prior to the appointment, to make sure we collect the appropriate amount owed and to make sure your visit will be covered by your insurance plan. However, it remains the policy holder's responsibility to know their insurance benefits. Ultimately, you are responsible for knowing what services are covered, how often, and how much of the cost is your responsibility. You will be responsible for any portion of services that our insurance deems is your responsibility.

CLIENT NAME

CREDIT CARD PAYMENT AUTHORIZATION

Please complete all fields. You may cancel this authorization at any time by contacting us.

Credit Card

☐ Visa ☐ MasterCard ☐ HSA ☐ Discover ☐ AMEX

Cardholder Name

Account Number

Expiration Date MM/YY

CVV (3 or 4 digits on front or back of card)

Billing Information
Billing Address

City, State, Zip

Phone Number

Email

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Alase Center for Enrichment in writing of any changes in my account information or termination of this authorization. I, the client or authorized representative (financial/Power of Attorney) certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my credit card company as long as the transactions correspond to the terms indicated in this authorization form.

Type Name

Client or Authorized Signature/Power of Attorney (POA):

Date Signed: