<u>BEFORE YOUR FIRST APPOINTMENT</u>

Please read the check list below if you choose to use your health insurance. We do not verify coverage here in this office as each of our clinicians is independently licensed with different insurance providers. If your claims are denied due to your clinician not being in network for you or "no authorization", you will be responsible for any balance due. Payment is required on your copay, and/or unmet deductible amounts, at the time of your visit.

My appointment is with ________________________on_____________at____: ______

<u>Below is a checklist for you to help you prepare for your first appointment</u>

___ I have verified that (clinician name) ___________ is in network for my insurance plan.

YES or NO

*If **NO**, please note this is <u>your responsibility</u> to verify coverage.

___ What is my co pay amount? _________ Do I have a deductible? **YES or NO**

___ What is my UNMET deductible amount? ________

___ Does your insurance plan offer (**EAP**) Employee Assistance Program benefits and if so, will you be using them? **YES or NO**

*If **YES,** this must be set up <u>prior to your first appointment</u> through your insurance provider. Please be sure to print out the email your insurance sends you with the information (*dates, number of sessions, authorization number*) and bring with you to this first appointment. **<u>Not all of our clinicians</u>** accept EAP benefits.

Please call our office 740.587.5252 if you have any questions.

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Couples Information

Client #1: ________________________________ Date of Birth: _______________

Address: ____
Street City State Zip

Sex: Male Female Social Security Number: ______________________________

Telephone Number: Home (___) ________________ Cell (___) _______________

Work (___) ____________________ Ext: ______

Email for appointment reminders____

If necessary, may we call you at work, if we do not identify ourselves? YES NO

Client #2 ________________________________ Date of Birth: _______________

Address: ____
Street City State Zip

Sex: Male Female Social Security Number: ______________________________

Telephone Number: Home (___) ________________ Cell (___) _______________

Work (___) ____________________ Ext: ______

Email for appointment reminders____

If necessary, may we call you at work, if we do not identify ourselves? YES NO

Responsible Party

Name: ____ Relationship to client __________

Address: ____
Street City State Zip

Email address for payments/insurance____

Primary Insurance Policy

Insurance Company: ____

Employer's Name: ____

Name of Insured: _________________________________ Insured's SS Number_________________

Insured's Identification Number: ______________________ Insured's DOB: ______________________

Client's relationship to insured: Self____ Spouse____ Child____ Other____

Secondary Insurance Policy

Insurance Company: ____

Employer's Name: ____

Name of Insured: _________________________________ Insured's SS Number_________________

Insured's Identification Number: ______________________ Insured's DOB: ______________________

Client's relationship to insured: Self____ Spouse____ Child____ Other____

Assignment of Benefits and Release of Information

I authorize NGC to release information necessary to effect treatment and claims payment. I also authorize payment of medical benefits be made directly to the provider.

Signed: ____ Date: __________________

Telephone Consumer Protection Act (TCPA)

I authorize a representative of NGC and/or any entity authorized by NGC, including those using automated dialing systems, automated messages, email, text messaging or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address provided.

Email address: ____

Signed: ____ Date: _______________

Consent to Treat

I agree to mental health and/or alcohol and drug treatment as offered by NGC for:

____Myself ____My Child ___The person for whom I am legal guardian.

I acknowledge this consent is voluntary and does not include medication/somatic (psychiatric) services.

I give consent for the use of my protected health information for treatment and payment as described in the Notice of Privacy Practices

I further acknowledge that I may revoke, in writing, this consent at any time except to the extent that action based on this consent has already been taken.

Signature: ____Reviewed by Clinician: __________

Date: __________________ Date: ________________

Emergency Contact

In case of emergency, contact ____

Phone number: (_____) ______________________

Client name #1____________

	Date last used:	How often:
Alcohol	______________________	______________________
Marijuana	______________________	______________________
Tobacco	______________________	______________________
Cocaine	______________________	______________________
Caffeine	______________________	______________________
Ecstasy	______________________	______________________
Codeine	______________________	______________________
Steroids	______________________	______________________
Inhalants	______________________	______________________
Stimulants/Amphetamines	______________	______________________
Sedatives	______________________	______________________
Opiates	______________________	______________________

Please check the following that apply to you:

___ Numbness or tingling
___ Shortness of breath
___ Racing heart, palpitations
___ Dizziness, blackouts
___ Nausea, diarrhea, stomach pain
___ Hot flashes, chills
___ Excessive sweating, moist palms
___ Feeling shaky, twitchy.
___ Headaches, body aches
___ Startle easily
___ Worry a lot
___ Road rage.
___ Lose temper easily
___ Feeling edgy, restless.
___ Difficulty concentrating
___ Confusion, indecisiveness

___ Memory problems
___ Fatigued easily
___ Difficulty sleeping
___ Sleeping too much.
___ Appetite low / high (circle the one that applies)
___ Lost interest in usual activities
___ Feeling hopeless
___ Binge eating.
___ Excessive exercise
___ Dieting
___ Self-induced vomiting
___ Using laxatives or diuretics to lose weight.
___ Excessive hand washing, fear of germs
___ Excessive checking (doors, locks, etc.)

___ Excessive need for order or counting things.
___ Excessive need for order
___ Inability to throw things away.
___ Failure to complete chores or homework.
___ Forgetful in day-to-day activities
___ Make careless mistakes regularly
___ Fidget a lot
___ Impulsive
___ Overspending or gambling
___ Sexual problems
___ Shame
___ Fear of criticism or fear of being embarrassed

In response to a very stressful situation.

__repeated/unwanted memories
__disturbing dreams
__feeling upset when reminded of event
__physical reactions to reminders
__avoidance internal/external reminders
__blame self

__feeling distant/cut off
__super alert or on guard
__risky behavior
__negative beliefs about self, others, world
__strong negative feelings/lack of positive feelings.

Describe the reasons for making this appointment:

How long have you had these concerns?

What have you tried to help with these difficulties?

List stressful events:

Do you have cultural, ethnic, or religious needs that may impact your treatment?

What are your major sources of emotional support?

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Client name #2_____________

	Date last used:	How often:
Alcohol	______________________________	________________________________
Marijuana	____________________________	________________________________
Tobacco	______________________________	________________________________
Cocaine	______________________________	________________________________
Caffeine	______________________________	________________________________
Ecstasy	_______________________________	________________________________
Codeine	_______________________________	________________________________
Steroids	_______________________________	________________________________
Inhalants	______________________________	________________________________
Stimulants/Amphetamines	_______________	________________________________
Sedatives	______________________________	________________________________
Opiates	______________________________	________________________________

Please check the following that apply to you:

___ Numbness or tingling
___ Shortness of breath
___ Racing heart, palpitations
___ Dizziness, blackouts
___ Nausea, diarrhea, stomach pain
___ Hot flashes, chills
___ Excessive sweating, moist palms
___ Feeling shaky, twitchy.
___ Headaches, body aches
___ Startle easily
___ Worry a lot
___ Road rage.
___ Lose temper easily
___ Feeling edgy, restless.
___ Difficulty concentrating
___ Confusion, indecisiveness

___ Memory problems
___ Fatigued easily
___ Difficulty sleeping
___ Sleeping too much.
___ Appetite low / high (circle the one that applies)
___ Lost interest in usual activities
___ Feeling hopeless
___ Binge eating.
___ Excessive exercise
___ Dieting
___ Self-induced vomiting
___ Using laxatives or diuretics to lose weight.
___ Excessive hand washing, fear of germs
___ Excessive checking (doors, locks, etc.)

___ Excessive need for order or counting things.
___ Excessive need for order
___ Inability to throw things away.
___ Failure to complete chores or homework.
___ Forgetful in day-to-day activities
___ Make careless mistakes regularly
___ Fidget a lot
___ Impulsive
___ Overspending or gambling
___ Sexual problems
___ Shame
___ Fear of criticism or fear of being embarrassed

In response to a very stressful situation.

__repeated/unwanted memories
__disturbing dreams
__feeling upset when reminded of event
__physical reactions to reminders
__avoidance internal/external reminders
__blame self

__feeling distant/cut off
__super alert or on guard
__risky behavior
__negative beliefs about self, others, world
__strong negative feelings/lack of positive feelings.

Describe the reasons for making this appointment:____
____
____

How long have you had these concerns?

____
____
____

What have you tried to help with these difficulties?

____
____
____

List stressful events:

____
____
____

Do you have cultural, ethnic, or religious needs that may impact your treatment?

____
____
____

What are your major sources of emotional support?

____
____
____

Office Policy

Welcome to *Newark Granville Counseling*. We are pleased that you have selected us to aid you in a healthier life. We want to make your visits as easy as possible by providing information that will help you with our office procedures. Feel free to discuss any concerns you have with your therapist.

Please be sure to bring these items with you for each session: ***Insurance Card & Payment (cash, check, or HSA/credit card).*** We may not be able to see you if you do not bring these items.

Are there any considerations I need to know before entering the counseling process?
The treatment process will be most helpful to you when you are honest and trust the process. We honor your presence and will work with you to make this a beneficial experience.

How long does each appointment take and how long will I be in counseling?
Appointments can be anywhere from 45 to 50-minute sessions. Your individual needs are determined by you and your therapist and will dictate the frequency of appointments and the treatment duration.

How can I be assured that my records are confidential?
State and Federal laws govern that your records are confidential. We release information with your signed permission. Please be aware of several rare exceptions to confidentiality. In situations of possible harm to you or another, suspected child abuse or neglect, or when a court subpoenas your records, your therapist may be required to release confidential material. You should be aware all insurance companies require a clinical diagnosis. Sometimes we have to provide additional information such as a treatment plan or summaries, or copies of the entire record (in rare instances). This information becomes part of the insurance company files. While the insurance companies do have to follow the same practices as we do regarding confidentiality, we have no control over what they do with your records. We will be glad to share with you any information released to your insurance company. Please refer to the Notice of Privacy Practices for additional information.

What if I want to switch therapists?
We believe that you, as a consumer, need to be comfortable with the services provided. If you would like a different therapist, please discuss this in treatment. It is important that you have a therapist that meets your needs.

What if I have an emergency that can't wait until my next appointment?
If you call our office during regular business hours, we will try to have an available therapist respond to your needs. If there is not an available therapist, or if you have an emergency after business hours, please call 911, 211, or the Crisis Line 345-4357 (345-HELP) or go to the nearest emergency room.

Are there special considerations if I am bringing my child for treatment?
If the client is a minor, a custodial parent must sign a permission form authorizing services. Oftentimes the therapist will need to obtain background information from the parent to aid in the treatment process. The therapist will explain to you and your child how confidentiality works in such cases. The sessions may be divided to allow for parental consultation time. Your therapist will discuss this with you. In the case of divorce, both parents will be considered equally responsible for payment. Whoever brings the child to the office is responsible for payment at the time of the visit.

Thank you for reading this information. If you have questions about these or other matters, now or during your treatment course, please discuss them with your therapist. Dealing with these issues is often an important part of treatment. We look forward to meeting with you. If you would like a copy of these office policies for your records, please ask our Office Manager.

I HAVE READ AND UNDERSTAND THE PRECEDING INFORMATION AND AGREE TO FOLLOW THE POLICY.

______________________________________ ________________________
Signature of Client or Legal Guardian Date

Court Related Services

If required to testify in court or at a deposition involving your therapy, regardless of who initiates my involvement, a non-refundable retainer of $1500 is due within 24 hours of the subpoena being served, to block out my schedule to ensure my availability. If the subpoena is received without a minimum of 10 business days' advance notice, there will be an additional nonrefundable express charge of $500. You will be responsible for the retainer fee whether I testify or not; further, the cause of cancellation, whether it is initiated by the court or one of the interested parties is irrelevant.

When it comes to court actions the retainer will take care of the following:

- Preparation time
- Phone calls
- Preparing and/or filing a document with the court or the party who issued the subpoena.
- Mileage
- Time away from the office, including travel time, due to the subpoena and/or the inability to reschedule with clients once appointments are cleared in order to testify.

The following fees are not included in the retainer fee, and will be billed after the court appearance, and are due upon receipt.

- Actual time required to give testimony or deposition: $250 per hour.
- All attorney fees and costs incurred by the therapist as a result of the legal action.
- If records are requested, an additional cost, depending on who requests the records, will be charged in accordance with the Ohio Department of Health's then effective fee schedule, in accordance with ORC §3701.741.

I understand and agree to pay the fee structure as listed above.

____________________________________ ________________
Client or Guardian's Signature Date

____________________________________ ________________
Witness Date

Financial Agreement

Welcome to *Newark Granville Counseling Ltd*. We want to make your visits as easy as possible by providing information that will help you with our billing procedures. This agreement is in place in order to prevent the financial burden of an outstanding balance. ***Please read and initial each item.***

______***Credit/HSA cards on file***--New and existing clients are required to have a credit card on file even if you provide an HSA card as your primary. If you wish to pay **copays** by check those are due at the time of your appointment. If we do not receive your copay at the time of your appointment we will charge the card on file. Any outstanding balances, after insurance payment, will also be charged to the card on file (i.e. deductibles and additional copay amounts). Credit cards on file that are declined will be charged $40.00 processing fee, not an HSA. Email receipts from charges will come from *Practice Management Bridge*.

_____ ***Insurance Authorization***--Insurance providers may require authorization prior to an appointment (EAP requires an authorization). Your visit may be rescheduled, or you may be charged the full amount for the service if you do not provide this information at the time of your first appointment. Please note not all clinicians accept EAP.

_____***Returned Checks***-- An additional fee of $40.00 will be due for *checks returned* by your bank for any reason.

____***Account Balances***--Accounts may not carry a balance greater than $150.00. Additional appointments will not be scheduled until the outstanding balance is paid.

____***Overdue Accounts***--Interest may be charged when the bill is delinquent. We reserve the right to turn the account over to a collection agency. You will receive notification from us prior to collection action with ample time to pay your bill. As is permitted under law, we will release your name, address, and the amount owed, should the delinquency continue. Once an account has been forwarded to collections you will be unable to reschedule with any member of the practice until the balance has been resolved.

____***Missed Appointments***--24-hour advanced notice is required if you need to cancel or reschedule an appointment. We recommend replying to the email appointment reminder so that there's a time stamp. You can also choose to leave a voicemail on your clinicians' private voicemail. We reserve the right to charge **$50.00 if we are not notified 24 hours** in advance. If you miss an appointment without notice, a rescheduled appointment cannot be guaranteed. Repeated failure to keep your appointment may result in you being dismissed as a client. Insurance does not cover this fee and cannot be charged to your HSA card, which is why we require a credit card on file.

____***Telephone Calls***--There is no charge for the initial 10 minutes of a phone call to your therapist. After 10 minutes, your charge will be prorated at our regular hourly fee. Most insurance companies do not cover telephone calls (not referring to tele health).

____***Additional Costs***--Time spent on your behalf outside of counseling sessions (e.g. school consultation, court appearances, court preparations, hospitalization arrangement, etc.) result in an additional prorated billing. Routine letter writing or reports on behalf of the client will be subject to $80/hr. fee. Court related time, as outlined in "Court Related Services", constitute additional fees. **Payment is expected prior to the court appearance and/or any documents being released.** Please allow 10 business days for turnaround time for reports, forms and letters written on your behalf.

____***Billing***--Paumier Medical Management Group (PMMG), our outside billing agency, submits insurance claims on your behalf and may send bills for outstanding balances.

FEES

Initial Office Visit -$185
Ongoing appointments, Individual, $170
Ongoing appointments, Family, $160

SELF-PAY

Individual sessions -$125
Couples sessions -$150

I HAVE READ AND UNDERSTAND THE PRECEDING INFORMATION AND AGREE TO FOLLOW THE POLICY.

Client Name: ____________________________________Reviewed by Clinician: ____________________

Signature: ______________________________________Date: __________________________________

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, that patient, significant new rights to understand and control how your health information is used. “HIPAA” provides penalties for covered entities that misuse personal health information.

As required by “HIPAA”, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment, or to a collection agency if necessary.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and discloses will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information. **Protected health information** covers any identifiable information in the file, information compiled in reasonable anticipation of, or for use in a civil, criminal, or administrative action or proceeding, and certain

information used for research situations. You can exercise your rights by presenting a written request to the Privacy Officer, *McKenzie Povlinko*, LPCC-S, MFT, (740) 587-5252.

You have the right to:

- Request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- Reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- Inspect and copy your protected health information.
- Amend your protected health information.
- Receive an accounting of disclosures of protected health information.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Any individual or others filing a complaint will not be intimidated, coerced, threatened, or discriminated against, provided the individual(s) is acting in good faith, believe the practice opposed is unlawful, and the manner of opposition is reasonable, involving the disclosure of protected health information.

Please contact us for more information:

McKenzie Povlinko, LPCC-S, MFT
Privacy Officer
Newark Granville Counseling, Ltd
945 River Rd
Granville, OH 43023-9169
740.587.5252

For more information about HIPAA or to file a complaint:

The US Department of Health/Human Services
Office of Civil Rights
200 Independence Ave., SW
Washington, DC 20201
(202) 619.0257
Toll Free: 1.877.696.6775

Notice of Privacy Practice Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: ____

Client Name: ____

Relationship to client: ____

Date: ____

OFFICE USE ONLY

I attempted to obtain the client's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement but was unable to do so as documented below.

Date:	Initials:	Reason:

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INFORMED CONSENT ADDENDUM FOR TELEMENTAL HEALTH

This is to be used in conjunction with, but does not replace, the Consent to Treat document that is required of all clients prior to starting therapy services.

What is Tele mental Healthcare?

Tele mental healthcare includes the practice of diagnosis, treatment, education, goal setting, accountability, referral to resources, problem solving, skills training, and help with decision making, through the use of internet-based videoconferencing or phone calls. Telehealth psychotherapy may include psychological health care delivery, consultation, coaching, and/or counseling. Telehealth psychotherapy will occur primarily through interactive audio, video, and telephone communications.

Risks of Tele mental Health

1. Technological failure, such as unclear video, loss of sound, poor connection, or loss of connection.

2. Nonverbal cues are less readily available to both the therapist and the client.

Benefits of Tele mental Health

1. Less limitations by geographical location.

2. Reduction of travel to a physical office, which includes decrease in travel time.

3. Participation in therapy from your own home or the environment of your choosing.

Tele mental health delivery by *Newark Granville Counseling, LTD* may occur only with current residents of Ohio. The current laws that protect privacy and confidentiality also apply to tele mental health. Any exceptions to confidentiality are described in the Informed Consent document.

All existing laws regarding client access to mental health information and copies of mental health records apply.

No permanent video or voice recordings are kept from tele mental health sessions. Clients may not record or store video conference sessions or face-to-face sessions.

Expectations of client during each session

1 Minimum bandwidth connection of 384 kb or higher. (generally, your phone will be sufficient)

2. Minimum resolution of 640x360 at 30 frames per second. (generally, your phone will be sufficient)

3.Operational web camera (HD 1080p is recommended). (generally, your phone will be sufficient)

4. Proper lighting and seating to ensure a clear image of each party’s face.

5. Dress and environment appropriate to an in-office visit.

6. Only agreed upon participants will be present. The presence of any individuals unapproved by both parties and not part of the treatment plan will be cause for termination of the session.

7. The client must disclose the physical address of their location at the start of the session. Unknown locations will be cause for termination of the session. This is to ensure we are "meeting" at a place that will protect your confidentiality (no coffee shops, grocery stores, etc.). We may not meet while you are driving.

8. The client shall also provide a phone number where they can be reached in the event of service disruption.

Tele mental health may not be the most effective form of treatment for certain individuals or presenting problems. Arrangements to meet via telehealth must be made in advance. *Newark Granville Counseling Ltd* reserves the right to reject requests to meet via telehealth if the clinician does not think the situation is appropriate or is unable to organize the technology in time to meet client request.

Response to technical difficulties

Should technical difficulties cause session disruption, *Newark Granville Counseling* will contact the client via preferred telephone contact. If the technical difficulties can be resolved quickly, the session will resume, and the client will not experience a shortened session length. If the technical issues cannot be resolved in a timely manner, the session will be rescheduled for a time when functionality is restored. The client will be contacted by telephone to develop a plan for continuation of the session.

Payment

Session costs are outlined in the *Office and Financial Policy*. Please refer to that document for a more detailed discussion of session cost and payment.

Contact between sessions.

Video conference technology is reserved for therapy sessions only. Please refer to the Office and Financial Policy document for cost of contact outside of scheduled video conference sessions.

____ ____________

Client/Parent or Guardian's signature *Date*

Newark Granville Counseling, Ltd
945 River Rd., Granville, OH 43023-9169
Correspondence Address: PO Box 481, Granville OH 43023
Phone 740.587.5252 **Fax** 740.587.2571
www.ngcohio.com Email: office@ngcohio.com

CREDIT CARD PRE-AUTHORIZATION FORM

The current healthcare system requires the client to be financially responsible for a large portion of their healthcare needs. NGC is committed to making the billing and payment process as easy as possible. Our policy **requires all clients** to have a credit card on file, even if you have an HSA on file as your first form of payment. We will run the card for each co-pay, after the insurance processes the claim for those clients who do not have a copay or for self pay clients. We run our payments through secure HIPAA compliant software where your information is stored in the processing companies' vault. For your protection, only the last four digits of your card will show in our system. You will receive an email receipt from each transaction which will come from *Practice Management Bridge*. (check spam/junk folder)

Cards on file will be used for, co-pay amount, co-insurance amount, unmet deductible amount, no show or late cancellation fee, and outstanding balances. If the outstanding balance is too large for one transaction, a payment plan may be worked out.

Please note if your credit card is declined there will be a $40 fee applied per declined transaction.

Client's Name: ____

Cardholder's Name: ____

Cardholder's Address: ____

City: ______________________ State: _______________ Zip: ________________

Credit Card Number: ____ Exp Date: __________

Cardholder's Signature: ____ Date: ___________

If you would like a receipt emailed to you when your credit card is charged, please include your email address below.

Email address ____

Account #____________ (OFFICE USE)

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HSA CARD PRE-AUTHORIZATION FORM

The current healthcare system requires the client to be financially responsible for a large portion of their healthcare needs. NGC is committed to making the billing and payment process as easy as possible. Our policy **requires all clients** to have a credit card on file with their HSA card on file. We will run the card for each co-pay, after the insurance processes the claim for those clients who do not have a copay or for self pay clients. We run our payments through secure HIPAA compliant software where your information is stored in the processing companies' vault. For your protection, only the last four digits of your card will show in our system. You will receive an email receipt from each transaction which will come from *Practice Management Bridge*. (check your spam/junk folder)

Cards on file will be used for, co-pay amount, co-insurance amount, and any unmet deductible amount. **Please note for HSA cards**: no show/late cancellation fees cannot be charged to the HSA card on file, which is the reason for the credit card. If the outstanding balance is too large for one transaction, a payment plan may be worked out.

Client's Name: ____

Cardholder's Name: ____

Cardholder's Address: ____

City: ______________________ State: _______________ Zip: ________________

HSA Card Number: ____ Exp Date: __________

Cardholder's Signature: ____ Date: ___________

If you would like a receipt emailed to you when your credit card is charged, please include your email address below.
Email address ____

Account #_________(OFFICE USE)

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