FOR OFFICE TO COMPLETE
Client: _____
Practitioner: _____
Auto-Pay? ___ YES ___ NO
Self-Pay? ___ YES ___ NO
Staff Date/Initials _____

Confidential Care
Pre-Authorized Credit Card Payment Form

Our policy is to keep a credit card on file to cover any unpaid balances. If you have a balance due to insurance lack of payment, missing an appointment, or cancelling within a 24 hour time-frame not due to an emergency or illness you have the option of choosing how you will pay for your visits and unpaid balances on your account. We assure you that your information is respected with the highest level of confidentiality, is not shared with any other source, and is securely protected separately from your therapy file.

I, _____ authorize Confidential Care, LLC to keep my signature on file and charge my credit card account as indicated below for payment security.

Check one of the following options:

☐ **ONLY FOR MISSED APPOINTMENT/UNPAID BALANCE**

I want to choose how I pay each visit and keep card on file only for unpaid missed appointments (no shows or cancelling within 24 hours) at my therapist's rate of $ _____ and at my medication provider's rate of $ _____ (Insurance will not cover missed appointments), and fees in the event insurance does not pay.

Confidential Care will send me a monthly billing statement noting the charges on my account and total balance due. I understand that if the outstanding balance is not paid in full within 20 days of my statement date and ***I*** have not contacted Confidential Care's billing office at 907-357-1999 to arrange a payment plan, my credit card on file will be charged the full amount that is owed to Confidential Care prior to their next monthly billing cycle. Confidential Care will email a receipt of the credit card charge to my email address after it has been processed.

Email address: _____

☐ **AUTO-PAY**

I want to have my card automatically charged each visit. This includes:

- **Self-pay, Insurance co-payment, co-insurance, or amount towards deductible** at time of each appointment: $ _____
- **Missed appointments** (no shows or cancelling within 24 hours) at my therapist's rate of $ _____ and at my medication provider's rate of $_____ (Insurance will not cover missed appointments)
- **If my sessions are to be covered by insurance, any unpaid balance in the event insurance does not pay.** This payment option allows Confidential Care to process for immediate payment the authorized charge(s) under this payment option. Confidential Care will email a receipt of the credit card charge to my email address after it has been processed and a monthly statement will be sent to me noting the charge(s) and authorized credit card payment transactions.

Email address: _____

Confidential Care agrees to only charge for the circumstances listed above and to keep my credit card information in a separate locked file. I agree to inform staff of any changes with my credit card (expiration date or number). If applicable, I also agree to inform staff of any changes or cancellation of my insurance policy.

CLIENT NAME: _____ **DATE:** _____

Pre-Authorized Credit Card Payment Form

CLIENT NAME: _____

CARDHOLDER NAME: _____

Account Number: _____

Expiration Date_____/_____ Security Code: _____ Zip Code where bill is sent: _____

Signature: _____ Date: _____

For office use only: