Soul Care **- CREDIT CARD PAYMENT AUTHORIZATION & PAYMENT POLICY*-**

THIS FORM, ONCE COMPLETED, IS FILED IN A HIPAA compliant secured server with ACCESS LIMITED TO ONLY THE PRACTICE MANAGER & OWNER

Thank you for choosing us as your mental health provider. We are committed to providing you with quality and affordable care. Because some of our clients have had questions regarding client and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is the client's responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Co-payments and/or co-insurances elected for payment by credit card will be charged to card on file below.

- My co-payment amount per session is _____; my deductible amount per year is _____.
- Have you met your deductible for this year? □YES □ NO If no, how much more do you have to pay towards your deductible?_____

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by your insurer. You must pay for these services in full at the time of visit.

- My session charges not covered by insurance are: Intake Charge_____ / Follow-up Charges_____

4. Proof of insurance. All clients must complete our client information form before seeing the doctor. **We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance.** If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. Most insurance providers will not pay any claims submitted 90 days after date of service.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be referred to another counseling agency. If there is mental health crisis during the referral process, our agency will provide interim emergency services only.

8. Missed appointments. Our policy is to charge a $35 fee for missed appointments that are not canceled 24 hours in advance. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

9. Recurring Credit Card Payment Authorization. It is our policy to obtain credit or debit card information from each client. This is to ensure that all payments will be collected according to the conditions within our payment policy. By completing the following information, you authorizing Soul Care Christian Counseling Services to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods and services.

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes to my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this card.

It is required that you show your preferred card to us during you first appointment for verification.

** This policy does not apply to Medicaid recipients.*

(Please fill out completely and sign.)

Client Name: _____

Visa ❒ Master Card ❒ Discover ❒ American Express ❒ Other ❒_____

Credit Card Number: _____ - _____ - _____ - _____

Expiration Date: _____(mo.)/_____(yr.)

CVC Number (last 3 numbers on the back of the card/4 numbers on the front of an AmEx card): _____

Signature: _____

Date this form signed: _____

Address with Zipcode:_____

Please print name as it appears on Credit Card: _____

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