RICHMOND CREATIVE COUNSELING

Credit Card on File Agreement

We have implemented a policy which enables you to maintain your credit card information securely on file with Richmond Creative Counseling (RCC). In providing us with your credit card information, you are giving RCC permission to automatically charge your credit card on file for your (or any other patient(s) you have listed on this form) co-pays/ co-insurance, outstanding balances, missed/ canceled appointment fees, services, and/or products.

Co-Pays/ Co-Insurance: Co-pays and co-insurances are due at the time of the office visit. You may still choose to make your payment by check, cash, or a card different from the credit card on file.

Outstanding Balance: If your insurance provider has paid their portion of your bill (or any other patient(s) you have listed on this form) and there is still an outstanding balance owed, RCC will charge the card listed below. By signing this form, you give permission for RCC to charge your card for any outstanding balance on your (or any other patient(s) you have listed on this form) account, including missed/ canceled appointment fees, contact fees, and outstanding co-pays/ co-insurances.

Services and Products: Self pay services and other fees are due at the time of the office visit.

This card will only be authorized for the use of the credit card holder or any person(s) listed below by the credit card holder. **This agreement will expire upon termination of services and settlement of final balance**. The card holder may also revoke this consent at any time in writing while understanding that continued services may not be available if an unpaid balance accrues.

All Information Must Be Completely Filled In Below

Visa MasterCard Discover American Express HSA/FSA

Credit Card Holder's Name: _____
(Please Print)

Credit Card Number: _____

Billing Zip Code: _____ CVV# (on back of card): _____ Expiration Date: ____/____

Please fill out the information below for any other person(s) for whom you authorize use of this credit card. If NO OTHERS ALLOWED, check the box below and initial.

No others allowed Initials:_____

Patient Full Name: _____ DOB: ___/___/___

Patient Full Name: _____ DOB: ___/___/___

Credit Card Holder's Signature: _____ Date: _____