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CREDIT CARD ON FILE POLICY

As a condition to providing treatment, Christine Clancy, PhD., ABPP, will require you to provide a valid credit card number for us to keep on file in order to secure payment for the portion of services that your insurance company will not cover, but for which you are responsible.

Your credit card information will be kept confidential and secure and only authorized staff will have access to the information as necessary to manage your account balance with us. Your supplied credit card will be charged only under the following circumstances:

1. After your claims have been processed by your insurer, and your insurance company determines your responsibility for any amounts due for the services you have received.

2. For all current patient balances, including co-pays, deductibles, co-insurance and charges not allowed by your insurance company (e.g., educational testing).

Authorization:
I authorize Christine Clancy, PhD., ABPP to charge the portion of my bill that is my financial responsibility to the following credit card:

☐Amex ☐Visa ☐Mastercard

Credit Card Number ____

CVV CODE: ____

Expiration Date _____ / _____

Cardholder Name ____

Billing Address for the Credit Card ____

City _____________________ State_______ Zip ___________

I, the undersigned, authorize and request Christine Clancy, PhD., ABPP to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by Christine Clancy, PhD., ABPP. This authorization will remain in effect until I cancel this authorization. To cancel, I must give a 60 day notification to Christine Clancy, PhD., ABPP in writing and the account must be in good standing.

Patient Name (Print): ____

Patient Signature: ___________________________________ Date: _____ / _____ / _____