Family Therapy Clinic

8480 Bluebonnet Blvd, Suite A
Baton Rouge, LA 70810-2879
Tel: (225) 292-0155 Fax: (225) 292-0157

Credit Card on File Policy

Due to changing co-pays, unmet deductibles, uncovered services, and missed appointment fees, account balances can balloon very quickly. In order to streamline billing/payments and avoid large balances we maintain a Credit Card on File Policy as follows:

1) After verification of insurance benefits, we will use your card only for the amount determined to be "patient responsibility". You may choose to use an alternative form of payment (e.g., cash, personal or cashier's check), but full payment will be required at the time of service.
2) Your card may be used for deductible & co-insurance amounts, any non-covered services, missed or inaccurate co-payments, and missed-appointment/late-cancel fees.
3) If your card on file changes, we require that you notify us immediately. If we run the card on file and it is denied for any reason, we reserve the right to charge an additional $25 fee.
4) If there are any questions or disagreements about charges to your card, we will investigate the matter as quickly as possible. In the event of an overcharge, we will refund the amount to the same card in a timely manner.

Please complete the information below:

Patient Name: _____
Patient Date of Birth:_____
Card Holder Name: _____
Relationship to Patient: _____
Billing Address: _____
_____
Card Type: □ Visa □ MasterCard □ Discover □ AmEx □ Other
Card Number: _____
Expiration Date: _____
CCV#: _____

Please sign and date below to indicate you understand and agree to the following:

- Family Therapy Clinic of Louisiana, LLC will keep my signature on file and charge the credit card listed above for the services provided to the above named patient.
- I have read and agree to abide by the Payment Policy and Credit Card on File Policy for Family Therapy Clinic of Louisiana, LLC.
- I understand it is my responsibility to notify the office immediately of any changes to the above listed credit card information. Any new credit card will be subject to the Payment Policy and Credit Card on File Policy that was authorized with the original card.
- I understand that this authorization is valid until such time that I cancel it through written notice to Family Therapy Clinic of Louisiana, LLC.

_____ _____

Cardholder Signature Date