Family Therapy Clinic of Louisiana, LLC
8480 Bluebonnet Blvd, Suite A,
Baton Rouge, LA 70810-2879

Credit Card on File Policy

These days, insurance benefits and coverage for services can be a very complicated business. We do our best to verify benefits and estimate a patient's responsibility prior to the service date. However, changing copays, unmet deductibles, uncovered services, and missed appointment fees can quickly raise a patient's account balance. In order to streamline our billing and payment system and prevent large balances for our patients, we have instituted a REQUIRED CREDIT CARD ON FILE policy at our clinic:

1. We will bill your insurance company first and upon their determination of benefits, we will charge your credit card only the amount listed as "patient responsibility". You are not required to use the credit card on file if you would prefer to use an alternative form of payment (e.g., cash, personal or cashier's check) and payment is made at the time of service.

2. Circumstances in which your card may be charged include, but are not limited to:

- Deductible and co-insurance amounts
- Any non-covered services and/or denial of services
- Missed or inaccurate co-payments
- Missed or canceled sessions without a 24-hour notice

3. If the credit card we have on file for you changes, we require that you notify us immediately by phone or email. If we run your credit card and it is denied for any reason, we reserve the right to charge an additional $25 fee if we are not able to run a new credit card within 7 days. Any new credit card will be subject to the financial policy listed here and may be used with the same authorization as the original card.

4. If there is a problem with your bill or claim and it is brought to our attention after your credit card payment processes, we will investigate the matter as quickly as possible. If it is determined that you have been overcharged, we will refund the overcharged amount to the same card in a timely manner.

Please complete the information below related to our Credit Card on File Policy:

Patient's Name: * _____

Patient's Date of Birth: * _____

Card Holder's Name: * _____

Relationship to Patient: * _____

Billing Address: * _____

_____

_____

_____

Card Type: * ☐ Visa ☐ MasterCard ☐ Discover ☐ AmEx

Card Number: * _____

Expiration Date: * _____

CCV# (last 3 digits on back): * _____

By entering my signature below, I:

1. Assign my insurance benefits to Family Therapy Clinic of Louisiana, LLC.

2. Authorize Family Therapy Clinic of Louisiana, LLC to keep my signature on file and to charge the credit card listed above for the services provided to the above named patient.

3. Acknowledge that I have read and agree to abide by the Payment Policy and Credit Card on File Policy for Family Therapy Clinic of Louisiana, LLC.

4. Understand that it is my responsibility to notify the office immediately of any changes to the above credit card information. Any new credit card will be subject to the Payment Policy and Credit Card on File Policy used with the same authorization as the original card.

5. Understand that this authorization is valid until such time that I cancel it through written notice to Family Therapy Clinic of Louisiana, LLC.

CARD HOLDER SIGNATURE: * _____

DATE: * _____