A Credit Card is required for self-pay, payment plans, and commercial insurance.

Our clients appreciate the convenience of using a credit, debit or health savings account to cover their portion of the medical costs. We take your card securely and notify you about any charges due after your insurance is applied.

As a service to our clients, we automatically submit your medical claim(s) to your health insurance company. When your insurance plan determines the amount that you owe as “patient responsibility,” we charge that amount on the card you provided.

If you owe any balance after your insurance pays, we will send you an email notification 10 days before your card is charged. The timing of this communication depends on how fast we hear back from your insurance company. It usually happens within 30 days of your visit, but it could take up to 90 days. If you owe any balance after your insurance pays, we will notify you within 90 days. If you do not have an email, we will send a letter that will arrive about 2 to 5 days before your card is charged.

If you do not want the credit card that was previously provided to be changed for any reason, please immediately contact our office at 574.651.8912 Option 0 to make other payment arrangements.

**Client Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name on Card if different than client:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Credit Card Type:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Credit Card Number \_\_\_ \_\_\_ \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_**

**Client Zip Code:** \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ **CVV Code: \_\_\_ \_\_\_ \_\_\_** **Exp. Date \_\_ \_\_/\_\_ \_\_**

I authorize Cornerstone Family Therapy to charge my credit/debit/health account card above for any co-payments and co-insurance incurred on my account including missed appointment fees on the date of service unless otherwise agreed upon in writing. I agree that no prior notification will be provided unless the amount changes, in which case I will receive notice from Cornerstone Family Therapy of such changes. If by the second notice, Cornerstone Family Therapy does not receive a response or a payment in full, at that time, any balance owed will be charged to my credit card and a copy of the charge will be mailed to me.

This in no way compromises your ability to dispute a charge or question your insurance company’s determination of payment. Also, this in no way compromises your ability to arrange or set up any needed payment arrangements.

**I verify that my credit card information, provided above, is accurate to the best of my knowledge.**

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_