17101 Snowmobile Lane Suite 109
Eagle River, AK 99577
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office@thetalkingplace.org
www.thetalkingplace.org

CREDIT CARD PREAUTHORIZATION FORM

I authorize The Talking Place, Child and Adolescent Counseling, LLC to keep my signature on file and to charge fees, or partial fees, to my Credit Card account for services provided to

_____
(Print Patient or Client Name)

for the balance of charges not paid by insurance and not to exceed the amount of the full fee as detailed in the "Agreement for Services" for each appointment including any fees for missed appointments, or appointments cancelled without 24-hour notice.

I AGREE THAT:

- If insurance health benefits are assigned to The Talking Place, Child and Adolescent Counseling, LLC I am sill responsible for the total charges incurred regardless of any insurance denial or insurance partial payments unless other arrangements regarding fees have been made in writing. This responsibility will be limited by any participating provider agreements The Talking Place, Child and Adolescent Counseling, LLC may have with an insurance company or network
- This authorization is valid until cancelled in writing
- Charges for ongoing services will be posted to my credit card account within one week of each service date, or in instances of deductible, co-insurance, and/or copayments, within one week of insurance check being posted to my account. All charges will appear on my statement as "The Talking Place, Child and Adolescent Counseling, LLC." The amount charged to my account will depend on use of service, insurance arrangements and agreement now in effect with The Talking Place, Child and Adolescent Counseling, LLC .
- If I have any problems or questions regarding any charges to my account, I will contact The Talking Place, Child and Adolescent Counseling, LLC, or the billing manager for assistance. I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with The Talking Place, Child and Adolescent Counseling, LLC or the billing manager.

I hereby authorize The Talking Place, Child and Adolescent Counseling, LLC to charge $ _____ per visit to cover the anticipated patient portion balance after insurance processing. I understand I may have additional balances owed after insurance processing which will be my responsibility.

Monthly Billing Date:

☐ 7th ☐ 14th ☐ 21st ☐ 28th

☐ Charge my Card for Each Session

Cardholder Name (please print clearly): _____

Billing Address (where credit card statements are mailed): _____

City: _____ State: _____ Zip: _____

Card Type (circle one): **Visa** **Master Card** **AmEx** **Discover** **Other**

Card Number:_____ Expiration: ____ / _____ CVV: _____

Cardholder Signature: _____ Date: _____