ADVOCATE PSYCHOTHERAPY SERVICES

SERVING ALL OF CENTRAL WISCONSIN — TO HELP YOU FIND WHAT'S MISSING

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CREDIT CARD AUTHORIZATION FORM

If you are using your insurance benefits, Advocate Psychotherapy Services, LLC ("APS") offers this form as part of an **OPTIONAL** request that the patient portion of the first (and subsequent) sessions be paid by a credit/debit card the same day your services are provided or we receive a Remittance Advice statement (i.e. payment information) from your insurance company about what you owe. The card information you can use includes a variety of HSA, Flex Spending, Rewards cards, or any others that have a Visa, MasterCard, or Discover Card logo.

This form has been created due to the high incidence of unreported deductibles and the fact that insurance may not cover Behavioral Health services. It is your responsibility to check on your own coverage and eligibility as APS does not check that for you ahead of time. In addition, many insurance coverage options now have changed to High Deductible Plans. The end result of these developments means that many sessions can be out to insurance at the same time resulting in a large balance due when finally processed. This can be a burden to the client as well as lead to significant balances for APS to carry as an entity.

By paying via credit card, you acknowledge that this credit card information will be automatically kept on file via PCI-compliant encrypted code with our merchant/credit card processor: **BluePay (www.bluepay.com)**. You further agree and understand that if insurance does not pay the contracted rate for services, that any remaining balance due is your responsibility and therefore will be charged to this credit/debit card. This amount typically includes co-pays, co-insurance, and deductibles that have not yet been met and match the Remittance Advice that both you and APS receive at the same time. After a charge is run, APS will send a credit card receipt via regular mail reflecting the charges applied to your credit card.

*By signing this form, I authorize APS to keep my credit card on file with its merchant system ("BluePay") and to charge my credit card an amount not to exceed **$250 per charge** for all balances due including any No Show Fees as described in the Informed Consent. This authorization expires 12 months from the date entered above.*

Signature: _____ Date: _____

Client Name: _____

Credit Card Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ CVV Code: __ __ __

Name on Card: _____ Expiration Date: _____

Billing Address:

Street: _____

City: _____State: _____ Zip Code: _____