Coping Partners™

CREDIT CARD ON FILE
AUTHORIZATION FORM

Dear Client/Parent/Guardian,

Please complete the following authorization to keep your credit card information on file. Even if you choose a different form of payment at the time of service, we require clients to have their credit card information on file with a signature authorizing a transaction if and when necessary or required per our policies, including when there is any outstanding amount owed. Accordingly, upon completing the form, please provide your signature under the "Office Policy" statement. Please note, you only need to sign the "Automatic Payment" line if you choose this form of payment and wish for us to automatically process payment upon services being rendered. All charges to your credit card will be reflected in the receipt you receive via e-mail, which you may submit directly to your insurance carrier for reimbursement. Of course, you are aware, that you are directly responsible for any outstanding balance on your account and that it is solely your responsibility to submit claims for reimbursement to your insurance carrier.

CREDIT CARD AUTHORIZATION INFORMATION

Name as it appears on card: _____

Account Number: _____

Expiration Date: _____ CVV 3-digit code: _____ Billing Zip Code: _____

Automatic Payment: I authorize Coping Partners/Children Coping Clinic to automatically debit my credit card number on file for current and future services rendered. I understand that I will receive a receipt via email for credit card charges in order to submit for insurance reimbursement if I so choose.

Signature _____ Date _____

Office Policy: I authorize Coping Partners/Children Coping Clinic to automatically charge my credit card on file for the outstanding balance if payment is not made at the time of the session. Note this must be signed for services to commence or continue.

Signature _____ Date _____