Emmaus Counseling Center

Therapist's Name: _____

Confidential Credit Card Authorization

Client's Name:_____DOB (mm/dd/yyyy):_____

HSA CARD INFORMATION **HSA Cards cannot be used to cover missed sessions, please provide an additional credit card below your HSA Card information that we may use for those sessions. Thank you!*

HSA CARD NUMBER: _____ EXP. (MM/YY): _____ CVV:_____

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NON HSA CARD TYPE: ☐ VISA ☐ MasterCard ☐ AMEX ☐ Discover ☐ Other:_____

CARD NUMBER: _____ EXP. (MM/YY): _____ CVV: _____

CARDHOLDER NAME (as shown on card): _____

BILLING ADDRESS: _____

RELATIONSHIP TO CLIENT: ☐ Self ☐ Parent/Guardian ☐ Partner/Spouse ☐ Other: _____

CREDIT CARD & BILLING POLICIES

We request that all clients provide a debit or credit card to keep on file in our secure electronic medical records program. Unless other arrangements are made with your therapist, Emmaus will charge your credit card for your copay or fee owed following your session and will collect coinsurance and deductible payments from the card on file at the time your insurance responds to our claim and has determined the exact portion owed by the client. Clients are responsible for tracking this claim and the amount due by carefully reviewing the Explanation of Benefits (EOB) mailed directly to the client by the insurance company. Clients will receive a **monthly e-Statement** (via email from our client portal) identified as "**Emmaus Billing (re: Invoice)**" which will prompt you to login to your **Secure Client Portal** to view. In addition, at any time you may check your account via your portal and view a real-time **Account Ledger**. Clients have a right to receive a statement of all charges, payments and balances associated with their account. A client who wishes to change their credit card on file may do so by notifying the billing department to update the credit card number on file and signing a new authorization form. A client who wishes to cancel a card on file must do so in writing, 5 business days prior to the date on which they wish the change to take effect.

BY SIGNING BELOW, YOU AGREE TO THE FOLLOWING: My signature below indicates that I understand and agree to pay for therapy as outlined in this agreement. I authorize the Emmaus Counseling Center to run my credit card listed above for any balance I accrue after my insurance has processed my claims. I understand that my card will be run without prior notice to myself, unless otherwise specified above and that a receipt will be provided via email. If I wish to terminate my credit card payment on file, I understand that I will need to give five (5) business days' notice for this to take effect. ***Please note***: ***parents or guardians of children under the age of 18 must have a signed authorization on file.***

_____	_____	_____
Signature of Card Holder	Printed Name	Date

Emmaus Counseling Center
8290 165th Ave. NE, Redmond, WA 98052
Billing Department p: 425.869.2644, ext. 18