

Emmaus Counseling Center

Confidential Credit Card Authorization

Client Name: _____ DOB (mm/dd/yyyy): _____

HSA/FSA CARD INFORMATION *HSA or FSA 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/FSA CARD NO. _____ EXP. (MM/YY): _____ CVV: _____

PLEASE FILL OUT BELOW FOR CHARGES NOT COVERED BY YOUR HSA/FSA

NON HSA/FSA CARD: 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.

Agreement & Authorization: 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

Credit Card Authorization Form

8290 165th Ave. NE, Redmond, WA 98052

This document contains personal and confidential information. Updated: 4/3/20