Credit Card Information

Client Name: ____ Date of Birth: ____________

Type: ☐ Visa ☐ Mastercard

Credit Card #: ______________________________________ Expiration Date: __________

Name on Card: ______________________________________ Security Code: ___________

Mailing Address Associated with Card:

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Street or PO Box City/State Zip

*I authorize Northstar Psychological Services, PLC 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 patient portal. 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.

____ ________________________

Client or Parent/Legal Guardian Signature (if client is under 18 years) Date

Email address to send credit card receipt via patient portal:

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Credit Card and Billing Policies

Northstar Psychological Services, PLC requests that clients provide a debit or credit card to keep on file in our secure electronic medical records system. Our biller, Cascade Therapy Billing, will charge your credit card for you copay or fee owed following your date of services and will collect coinsurance and deductible payments form 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 to carefully reviewing the Explanation of Benefits (EOB) mailed directly to the client by the insurance company. Clients will receive a billing statement via the patient portal.

Clients without a credit card on file will receive a bill via paper mail and will be subject to a $10 paper billing fee. Clients have the 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 Northstar Psychological Services, PLC to request a form to update the credit card number on file. A client who wishes to cancel a card on file must do so in writing, five (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 psychological services as outlined in this agreement.

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Client or Parent/Legal Guardian Signature Printed Name Date