CREDIT CARD ON FILE POLICY

At **Perlman Counseling and Supervision Services, LLC.**, we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable.

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

I authorize **Perlman Counseling and Supervision Services, LLC.** to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐ Amex ☐ Visa ☐ Mastercard ☐ Discover

Credit Card Number _____ Expiration Date_____ / _____ / _____

Cardholder Name_____ CVV/CVV2 code_____

Signature_____

Billing Address_____

City _____ State_____ Zip _____

I (we), the undersigned, authorize and request **Perlman Counseling and Supervision Services, LLC.** to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by **Perlman Counseling and Supervision Services, LLC.**

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60-day notification to **Perlman Counseling and Supervision Services, LLC.** in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____

Date: _____ / _____ / _____