ViewPoint
Psychological Services

Credit Card Authorization Form

Our practice policy is that all clients maintain a valid credit card on file to charge payments at the time of service, especially for any after hour appointments or appointments where minor clients will come alone. Cards on file will be used:

1. To pay any **unpaid charges** that may accrue as a result of having a deductible, co-payment, or any other fees agreed upon that were not paid at the time of service delivery, and to collect fees for assessment procedures/protocols that were not paid in full at the time of service or that were not paid by your insurance company.
2. To pay any **missed appointment** or **late cancellation** fees ($95 per missed appointment).
3. To pay any **Non-Sufficient Funds/Returned Unpaid Check** amount plus returned check fees.
4. As part of your payment plan for amount agreed upon (if applicable).

By signing below, ***I am certifying that I am an authorized signer*** on the card below and have permission to authorize charges. I am hereby providing my authorization and permission for Viewpoint Psychological Services, PLLC to charge my credit card for services rendered, co-payments/deductibles, or missed/late cancellation fees, non-sufficient funds or returned unpaid checks. I acknowledge that it is my responsibility to maintain an active, valid card on file.

I understand that no credit card information is stored within the practice. Once the information on this form is entered into the secure site initially, the card information will be redacted. When my card is electronically charged, staff at Viewpoint Psychological Services is only able to see the last 4 digits, not having access to the full card information to ensure privacy and security.

CLIENT'S NAME (Account to be credited):_____

PRINT NAME ON CARD:_____

SIGNATURE OF CARDHOLDER: _____
Note: the signature ***must* be that of the CARDHOLDER, not the client (if different).

LAST FOUR DIGITS OF CARD (if card has been swiped previously at our office)**:**_____

CREDIT CARD NUMBER (if card has not been used previously with us)**:**_____

EXPIRATION DATE:_____ **DATE SIGNED:** _____

Please be aware that timely payment of your account balance is your responsibility and a late fee equal to 2% of the total balance will be assessed per month for all unpaid balances, or in the case of a declined card.

**********FOR OFFICE USE ONLY**********

I have reviewed the forms and verified information in the system/and redacted credit card number:
Signed by (Staff): _____*Date Received:*_____

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Fort Thomas, KY 41075

2865 Chancellor Drive, Suite 105
Crestview Hills, KY 41017

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