CREDIT CARD GUARANTEE

[   ] SELF-PAY PATIENTS

If you: Are uninsured, have insurance that does not cover the cost of mental health counseling or we are out of network, or choose to pay out-of-pocket for other reasons, then you are responsible for full payment at the time of services. As a convenience to you, we will automatically charge your designated card below on the day of services.

Medication Evaluation: $225.00-$250.00	Therapist Evaluation: $135.00-$180.00
Med. Management follow up: $80.00-$110.00	Therapist Follow up sessions: $95.00-$140.00

We charge a **missed appointment fee of $75** or a **late cancel fee of $45** in the event that you miss or late cancel your appointment without giving **24-hours' business notice**.

[   ] INSURANCE PATIENTS

If you are using your insurance benefits, New Outlook Counseling Center, requires the patient portion of the first session be paid by credit – Visa or Master Card. This is due to the high incidence of unreported deductibles and the fact that insurance may not cover certain services such as Marriage Counseling, Family Counseling, and sessions lasting longer than 45 or 60 minutes.

By paying via credit card, you acknowledge that this credit card information will be automatically kept on file via PCI-compliant encrypted code with the following credit card processor: International Bancard. Health Savings Account cards may also be kept on file as the primary form of payment but must still have a back-up credit card on file in case HSA funds are depleted.

You further agree and understand that if insurance does not pay the contracted rate for services, any remaining balance due that is the legal patient responsibility will be charged to this Health Savings Card or Credit Card on file. This amount typically includes co-pays, co-insurance, and deductibles that have not yet been met or were quoted incorrectly by the insurance company.

New Outlook Counseling Center will provide you access to the TherapyAppointment patient portal where you can view your account, request statements, or pay your outstanding charges. Clicking on the payment line will allow you to view or print the receipt.

By signing my name below, I authorize New Outlook Counseling Center to keep my credit card on file and to charge my credit card an amount not to exceed $300. I have the right to request my credit card to be removed via written or verbal request.

THIS AUTHORIZATION EXPIRES 6 MONTH FROM THE DATE OF OUR FINAL THERAPY SESSION

______________________________________ __________________

SIGNATURE DATE

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CREDIT CARD: ❒ AMEX ❒ VISA ❒ MC ❒ DISCOVER

CARDHOLDER'S NAME ______________________________________ZIP CODE____________

CARD # _____________________________________EXP. DATE __________ CVV # _________