Laura Patin LMFT, LPC

Licensed Marital and Family Therapist # 226, Licensed Professional Counselor #381

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Credit Card Pre-Authorization Form

I/We authorize Laura Patin LMFT, LPC to keep my signature on file and to charge fees to my credit card account for services provided to:

Client Name: ______________________________________

For the balance of the charges not paid by either of the following: 1) copayments/cost-shares not covered by insurance company(s) for normal session visits, 2) deductible amount owed not covered by my insurance companies, 3) missed or late cancellation of appointments as outlined in the Agreement For Counseling Services signed by myself or my guardian.

I agree that:

- This authorization is valid until cancelled in writing.
- It is my responsibility to provide Laura Patin or Tina Paul, CPC-H, CPMA of Alaska Health Care Billing Service LLC (Account and Billing Representative of Laura Patin LMFT, LPC) with any changes to my credit card information within same said month changes have occurred.
- If I have any problems or questions regarding charges to my account I will contact Tina Paul, CPC-H, CPMA of Alaska Health Care Billing Service LLC (Account and Billing Representative of Laura Patin LMFT, LPC) or Laura Patin. I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with Alaska Health Care Billing (Tina Paul) or Laura Patin.
- Unpaid balances to my account may be referred to Cornerstone Collection Agency for reimbursement purposes should my account be considered delinquent. Laura Patin agrees to provide a written statement of accounts with unpaid balances at 30, 60, and 90 days following the last date of service provided. Accounts with an unpaid balance in effect after 90 days following the last service date will be automatically considered delinquent and my credit card will be charged for the remaining balance. If the credit card is delinquent or expired at that time, and I am unreachable after a reasonable amount of effort, services will then be referred to Cornerstone for reimbursement purposes.

Cardholder Name (please print)____ Billing Zip Code:__________________

Card Type (Circle One) Visa MasterCard Other:______________

Account #:______________________________ Exp. Date:_______________. CCV:__________

Cardholder Signature:__________________________________ Date:______________________