Credit Card On File Agreement

We have implemented a policy which enables you to maintain your credit card information securely on file with Replay Counseling Center, LLC. In providing us with your credit card information, you are giving Replay Counseling Center, LLC permission to automatically charge your credit card on file for your (or any other patient(s) you have listed on this form) co-pays/co-insurance, outstanding balances, services, and/or products.

Co-Pays/Co-Insurance: Co-pays and co-insurances are due at the time of the office visit. You may still choose to make your payment by check, cash, or a card different from the credit card on file.

Outstanding Balance: If your insurance provider has paid their portion of your bill (or any other patient(s) you have listed on this form) and there is still an outstanding balance owed, Replay Counseling Center, LLC will notify you via phone and/or mail. If the balance is not paid in full within 10 days of the notice, at that time, any balance owed will be charged to your credit card. A copy of the charge will be mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

Services and Products: Self Pay services and other fees are due at the time of the office visit. This card will only be authorized for the use of the credit card holder or any person(s) listed below by the credit card holder.

This agreement will expire upon termination of services and settlement of final balance. The card holder may also revoke this consent at any time in writing while understanding that continued services may not be available if an unpaid balance accrues.

☐Visa ☐ Master Card ☐ Discover ☐American Express Credit

Card Holder's Name: ____

Expiration Date: ____________________ (Please Print)
Credit Card #: ____
Billing Zip Code: __________________________ CVV# (on back of card): ________________

Please fill out the information below for any other person(s) you authorize this credit card for:
If NO OTHERS ALLOWED, strike through and initial.
Patient Full Name: ____ DOB: ____/____/____
Patient Full Name: ____ DOB: ____/____/____
Patient Full Name: ____ DOB: ____/____/____