Eating and Behavioral Health Associates, LLC

4041 N. High St, Suite 300D
Columbus, OH 43214
614.431.1418

Credit Card Consent Form

If you have the same debit/credit card, Flexible Spending Account (FSA), or Health Savings Account (HSA) card you would like to use for payment of services, you are welcome to keep this information on file with Eating and Behavioral Health Associates, LLC. This prevents you from having to remember to bring a specific card or your checkbook to each session, and your receipts for payment can be electronically sent to you. This also prevents our staff from having to reserve a portion of your appointment time to settle your account each session. This form is kept as part of your client file, and will NEVER be released to a third party unless we are legally obligated to do so. If you opt to bill payments for an appointment to a credit card number on file, your clinician will write "CC on File" on your super bill.

We assume that the funds are available on the stored card that day unless you tell us otherwise. If they are not, your clinician will contact you to alert you that the card has been declined. We ask that you then make prompt payment arrangements with your therapist. Please note that missed appointment fees are NOT generally able to be paid with an HSA or FSA card. Charges that may be reversed or declined by the credit card company for any reason remain the responsibility of the client/guarantor for payment.

Card Company (Check one):
☐Visa ☐MasterCard ☐Discover ☐American Express
Card Type (Check one):
☐Credit ☐Health Savings Account (HSA) ☐Flexible Spending Account (FSA)

Name on Card (Print Clearly): _____

Card Billing Address:_____

City: _____ State : _____ ZIP : _____

Card Number :_____

Card Expiration Date:_____ Email_____

☐I, _____, authorize Eating and Behavioral Health Associates, LLC to charge my credit/debit/health account card for professional services the day of our scheduled appointment. I understand that my information will be saved to file for future transactions on my account. If I do not cancel before 48 hours, I recognize that Sarah E. Altman, PhD will charge my card as a late cancel or no show if I do not show up for the appointment. I will be billed for the full session charge, and this fee is not reimbursed by the insurance company. The charge for the first missed therapy session is $175.00 and thereafter is $250.00. If I fail to provide payment for appointments within 30 days of the billing date, I authorize Eating and Behavioral Health Associates to charge my credit card the remaining balance.

☐ I, _____, prefer to make payment at the beginning of each session. I understand that my information will be saved to file for future transactions on my account. If I do not cancel before 48 hours or do not show up for my appointment, I recognize that Eating and Behavioral Health Associates, LLC will charge my saved card as a late cancel or no show if I do not show up for the appointment. I will be billed for the full session charge, and this fee is not reimbursed by the insurance company. The charge for the first missed therapy session is $175.00 and thereafter is $250.00. If I fail to provide payment for appointments within 30 days of the billing date, I authorize Eating and Behavioral Health Associates to charge my credit card the remaining balance.

I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing and initialing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

Signature: _____ Date:_____