p 410.863.7213 f 410.987.3154 www.pdgrehab.com
1110 Benfield Blvd, Suite B, Millersville, MD 21108

Credit Card Authorization Form

I hereby authorize the following charge(s) to be applied to my credit card which will be kept on file until treatment has been completed and my account balance is zero. A copy of the credit card is required for all self-pay clients and clients with private insurance. Your information will remain in a secured locked filing cabinet in a locked room to maintain the security of your information, or it will be stored in our HIPAA compliant, secured, password protected electronic medical records system (Credible Behavioral Health).

All insurance charges will be documented through your insurance's EOBs (eligibility of benefits) that are sent directly to you AND our office. No charges for insurance related issues will be charged to your credit card until we have received a denial of charges and have contacted you through e-mail to discuss the issue or resolve it, if it is an insurance error. If you do not respond within 24 hours to our e-mail for any billing issues your card will be charged for amounts due for: deductibles, co-pays, returned checks, denial by the insurance, missed appointments, forgetting your appointment, cancelling appointments without 24-hour notice, etc. It is your responsibility to provide your e-mail and update us of any changes to your e-mail so that communication can take place. We use e-mail so that communications can be documented appropriately in your chart.

- Missed Appointment for non-emergent situations ($75).
- Not attending scheduled appointments ($75).
- Cancelling appointments without giving appropriate 24 hours' notice ($75).
- Co-pays that are due at the time of service for family members, minors, spouses etc. if the co-pay is not remitted at the time of service (amount is determined by your insurance company).
- Deductible amounts that you are responsible for through your insurance (amount is determined by your insurance company at a contracted rate and varies depending on the services you receive).
- Any service amounts that are rejected by your insurance for lapse in coverage, not obtaining an appropriate referral, not providing the appropriate summary of your benefits which is required at admission or not securing your authorization for treatment through your insurance before admission (amount is determined by your insurance company).

Credit Card: _____Visa _____MasterCard _____Discover _____AMEX

Credit Card Number: _____

Expiration Date: _____ Credit Card Security Code: _____

I hereby authorize any of the above stated amounts be applied to my credit card:

Signature of Card Holder: _____ DATE: _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the services described above, for the amount indicated above or by your insurance company. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.