WPCS WESTERN PSYCHOLOGICAL & COUNSELING SERVICES, P.C.

Credit Card on File Agreement (optional)

We have implemented a policy which enables you to maintain your credit card information securely on file with Western Psychological and Counseling Services, P.C. In providing us with your credit card information, you are giving WPCS permission to automatically charge your credit card on file for your [or any other patient(s) you have listed on this form] co-pay/s, outstanding balance/s, and/or service/s.

Co-pays: Co-pays are due at time of the office visit. When using a credit card on file agreement, copays will be billed once a week for all services that week.

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, WPCS will notify you via phone and/or mail. If by the second billing notice from WPCS, we do not receive a response from you or your payment in full, 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.

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 on the expiration date listed below. The card holder may also revoke this consent at any time in writing.

Circle Card Type Below:

Visa MasterCard

Credit Card Holder's Name: ____ DOB: __/__/__

Credit Card Number: ___________________________________ Security Code _____ Expires: _____

Billing Address: ____

Cardholder's Signature ____ Date: ____________

Please fill out information below for any other person/s you authorize this credit card for:

Patient Full Name: ____ DOB: __/__/___

Patient Full Name: ____ DOB: __/__/___