



Card on File Agreement

Full Name as shown on credit card: _____

Complete Mailing address as shown on card account: _____

Family Members to be added for payment of services: _____

Type of credit card: Visa _____ Mastercard _____ Discover _____ Debit card _____ Credit card _____

Card Account Number: _____ Card Expiration: _____ (MM/YYYY)

E-mail address: _____ Telephone number to reach you: _____

Authorized Signature

Date

Authorized Signature

Date

I have read and agree with the Billing Rights information below.

Your Billing Rights

I/We hereby authorize Spence Counseling Center to charge this credit card on a weekly, monthly, or as-needed basis for the amounts due for services received and which match the patient responsibility amounts as determined by my insurance company and as reflected on the explanation of benefits (EOB's) the insurance company sends to me. Any overpayments on my account will be credited back to my card. My credit card statements will serve as receipts for payments processed. This designates my Signature on File and therefore it is not required that I sign paper receipts each time. This authorization is to remain in effect until the end date as listed above or until Spence Counseling Center receives written notification from me of its termination. If my bank account or credit card information listed above changes for any reason, I will notify Spence Counseling Center as soon as possible. If you think your charges are incorrect, please provide your name, account number, telephone number, and a brief written explanation of the problem. We will make any necessary adjustments to your account within 30 days. After 60 days all charges will be assumed to be correct.

In the event of a declined charge, your account will be charged a \$10.00 service fee for each occurrence.

Card Revoked _____ Date _____