ADIHEALTH

CREDIT CARD ON FILE AGREEMENT

We have implemented a new policy which requires all ADI Pediatric Behavioral Health (ADI Health) clients to keep a credit card on file for payment purposes. We have a new system which enables us to maintain your Credit Card information securely on file and which can only be accessed under the terms you specify below.

By providing us with your credit card information, you are giving ADI Health permission to automatically charge your credit card on a weekly, monthly, or as needed basis (if payment is not made by you within 30 days of an invoice) for the amounts due for services received. These amounts match the patient's responsibility amounts as determined by your insurance company and are reflected on the explanation of benefits (EOB's) from the insurance company.

Any canceled or missed appointments without a 48-hour notice will result in the credit card on file being charged the late cancellation/no show fee of $150.00. In addition, all self pay patients will be charged the date if their appointment.

If the credit card information we have on file changes for any reason, you must notify ADI Health as soon as possible. If you have any questions about a charge, please notify us within 15 days. After 30 days all charges will be assumed to be correct.

We will maintain a clear record of all payments and charges. However, in the rare case that an overpayment occurs, your account will be credited on the upcoming invoice or if the balance is zero and you have taken a break from therapy a reimbursement can be put back on the same credit card. You may request a paid invoice / "Superbill" from ADI Health showing your payment.

In the event of a declined charge, you will be asked for a new credit card number and/or payment before continuing treatments.

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I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE CREDIT CARD ON FILE AGREEMENT AND AUTHORIZE ADI PEDIATRIC BEHAVIORAL HEALTH TO SAVE AND CHARGE MY CREDIT CARD AS OUTLINED IN THIS AGREEMENT, AND AS PER ADI PEDIATRIC BEHAVIORAL HEALTH'S OFFICE POLICIES.

Patient's Name: _____

Email address connected to the patient's OnPatient Account:_____

Credit Card Information

□ Visa □ MasterCard □ Amex □ Discover

Card Number: _____ Exp. Date: _____ / _____

Security Code or CID #:_____ Billing Zip:_____

Name on Card: _____

Billing Address on Card (if different from our records):

Name on Card: _____

Street Address: _____

City: _____ Zip: _____

Would you like your card to be automatically charged when you have a balance?*

□ Yes □ No

Would you like to opt out of receiving paper statements?

□ Yes □ No

Signature: _____ **Date:** _____

**This option is not available to SELF PAY PATIENTS. All self pay patients must pay at the time of their appointment. If a payment is not on file, you will be automatically charged to your card on file.*