The Atrium
4 Terry Drive, Suite 11, Newtown, PA 18940
Phone: 215-550-1818
e-mail: DrLevy@buckscountyanxietycenter.com
www.buckscountyanxietycenter.com

Credit Card Form

Patient's Information:

Name: _____

Address: _____

Phone number: _____

Date of Birth: _____

Credit Card Information:

Name on card: _____

Credit Card Number: _____

Security Code: _____ Expiration Date: _____

Use of Credit Card Information by Bucks County Anxiety Center:

By signing this form you agree to pay all applicable fees associated with using your insurance such as co-pays, co-insurance, rejected claims or any other type of outstanding balance.

By signing this form you agree to provide Bucks County Anxiety Center with a credit card number that will be kept on file and will be charged in the event that you do not pay your balance due.

Co-pays and co-insurance are due at each session. They can be paid by cash, credit card, or check. Checks will be made out to **Bucks County Anxiety Center**.

You are responsible for all fees that are not paid by your insurance company such as co-insurance or any rejected claims. **Balances must be paid within 2 weeks or your credit card will be charged for the amount you owe.**

Patient Signature: _____ Date: _____

Patient's Name: _____ Date: _____

Parent/Guardian's Signature: _____ Date: _____

Parent/Guardian's Name: _____ Date: _____