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

Credit Card Form – Patient Using Someone's Credit Card

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 authorize Bucks County Anxiety Center to use the credit card information you are providing to pay for services provided to the patient as well as any fees they incur such as late cancellations, not showing to appointments, and other charges explained below. Your initials indicate you have read this _____(initials)**

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

- By signing this form, you agree to pay all fees the patient will be charged for any services provided by Bucks County Anxiety Center if the patient is paying out of pocket. If the patient is using insurance, you agree to pay for services not covered by insurance.

- 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 if the patient does not pay their balance.

- Co-pays, co-insurance, and out of pocket fees 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**.

- The patient is responsible for all fees that are not paid by their insurance company such as co-insurance or any rejected claims. **Balances must be paid immediately, or your card will be charged.**

- Phone sessions are charged the day they take place.

- **Late cancellations are charged the day they occur.**

For the patient's convenience, we can charge their balance to your card on file after each session. **Please initial here if you would like us to charge your card automatically** _____

For privacy reasons, we cannot discuss anything related to a patient over the age of 18 (e.g., charges, attendance, cancellations, sessions, treatment) even though we are charging your card. The patient must sign consent first. **Please initial to indicate you understand that your card will be charged for services and fees we cannot discuss with you if the patient is over the age of 18** _____

Patient Signature: _____ Date: _____

Patient's Name: _____ Date: _____

Parent/Guardian's Signature: _____ Date: _____

Parent/Guardian's Name: _____ Date: _____