The Atrium
4 Terry Drive, Suite 11, Newtown, PA 18940
Phone: 215-550-1818
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Credit Card Form – Patient Using Their Own 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 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 pay all fees you are charged for any services provided by Bucks County Anxiety Services if you are paying out of pocket or 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 you do not pay your 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**.

- 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 immediately, or your card will be charged for the amount you owe.**

- Phone sessions are charged the day they take place.

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

- For your convenience, we can charge your balance to your card on file after each session. Please initial here if you would like us to charge your card automatically ____________

Patient Signature: _____________________________________ Date: ___________________

Patient's Name: ______________________________________ Date: ___________________

Parent/Guardian's Signature: ______________________________ Date: ___________________

Parent/Guardian's Name: _________________________________ Date: ___________________