



Heights Anxiety and Depression Center

No matter how hard the past, you can always begin again.

Credit Card Authorization

THIS FORM, ONCE COMPLETED, IS FILED IN A HIPAA compliant secured server with ACCESS LIMITED TO ONLY THE PRACTICE MANAGER

Financial Policy: We accept most insurance. If we are not on a specific insurance panel and considered out of network, you will be financially responsible for the visit. Payment is due at the time of service. We accept any major credit card and personal checks.

No Show Fees Policy /Psychotherapy late cancellation/no show appointments: \$60

A block of time is reserved for your appointment. If you must cancel the appointment for any reason, please give us 24-business hrs. of advanced notice. If you fail to give us the advanced notice to cancel your appointment, then we will charge the following amount: \$60. Please be advised that if you miss or no show, to more than 4 appointments in one calendar year, then we reserve the right to refuse providing service at our clinic and will encourage you to follow-up with a different provider in the community. Upon termination of therapy the clinician will assist the client in finding other services or another therapist, when necessary. Closure is an important part of the therapeutic relationship for both the patient and the clinician. For this reason, we encourage a termination appointment for all patients that are ending individual therapy.

Fee for Service:

- Co-payments and/or co-insurances elected for payment by credit card will be charged to card on file below.
- The balance of charges for services rendered, but not paid by the insurance company within (30) days from the date of service will be collected from the card on file below.
- The \$60.00 no-show/missed appointment fee for failing to notify the clinic 24-hours prior to the scheduled appointment. (This cannot be billed to the insurance company)
- Telephone calls with the clinician outside the appointed time which last longer than 10- minutes would be charged at a rate of \$30 per 15-minute increment.
- E-mail responses from the clinician requiring more than 10-minutes to compose would be charged at a rate of \$30 per 15-minute increment.
- Copying/scanning of your file (for the purposes of sharing with your attorney, CPS, school, employer, etc.) at a rate of \$20.00 for first 25 pages.



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- Completion/Preparation of Reports or Letters at a rate of \$120.00 per hour, with a \$60.00 minimum.
- Legal testimony at a rate of \$225.00 per hour (to include travel).
- Sessions via telephone or teleconference: Your insurance may not cover this service. Any sessions provided via phone or teleconference will be billed at the regular rate as an in-person session regardless of insurance coverage, unless you elect the Private Pay Rate as shown below.
- Private Pay Rate:
 - o Individual 60-minute session \$120 per hour
 - o Family 60-minute session \$140 per hour

Credit Card Policy: Your credit card will be stored in our HIPAA compliant secured servers and will be used to charge your account towards any pending payments including but not limited to – Co- Pays, Co-insurances, Office visits, No- Show fees. By signing this consent form, you agree to give Heights Anxiety and Depression Center, INC the permission to charge your credit card remotely for any outstanding payments.

Client Name

Client Date of Birth

Credit Card Number

CVV Code (Front of card for AMEX)

Expiration Date

Name as it appears on Card

Billing address associated with the credit card

State and Zip

Cardholders Signature

Date