The Self-Care Path, LLC
1333 Burr Ridge Parkway, Suite 200
Burr Ridge, Illinois 60527
Phone: 708-429-0353
Fax: 386-263-8326
www.selfcarepath.com

AUTHORIZATION TO SECURE PAYMENT

I, _____ authorize my provider to process payments on the card listed below for services and/or **for any balance due that has not been paid.**

Payment Terms and Conditions, initial at each section:

_____**All new patients will provide a $50.00 deposit** prior to their first visit/appointment on the day of scheduling their first appointment. This deposit will be refunded OR applied to a cancelled / missed / rescheduled appointment with less than a 24-hour notice. It may also be applied to a balance (i.e. co-pay or deductible).

_____Patients are responsible for knowing whether they have mental health services coverage; and patients are responsible for knowing if they need authorization for mental health services. Any unpaid balances will be paid by the card on file.

_____If insurance rejects a claim because of a patient's negligence in any capacity, the balance must paid by the client. The office administrator will issue a CMS 1500 Form to patients so that they can apply to be reimbursed.

_____Please note that co-pays, deductibles, and other balances on accounts that are using insurance will be processed on the day the insurance pays.

_____You must notify us immediately if your insurance changes, otherwise you may owe the full amount of your balance if/when old insurance declines a claim.

____You are responsible for keeping an active card on file. You can update your payment information by calling the office, or via our online client portal.

____The Self-Care Path, LLC reserves the right to charge your account for any balances that accrue from your bank or credit card company fees. This tends to happen when you stop payment, or file fraudulent charges on legitimate charges.

_____Please be aware of our 24-hour cancellation policy. By signing this form, you agree to the following statement: I understand that if the appointment is missed and I do not follow the cancellation policy as specified, my provider is authorized to charge my payment card **$50.00 for the missed appointment**. I understand that if my card is declined, my provider will charge the payment on another day when funds become available.

_____Please be aware that **therapy sessions are 50 minutes** from start to end unless otherwise agreed upon. Please be courteous of your therapist's schedule, and others' appointments.

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To contact our office administrator, Lisa Gura, you may call the office at 708-429-0353 or email: selfcarepath@gmail.com. I have read and understand this form. I attest that the information below is true and accurate.

_____ _____
Signature of Cardholder Today's Date

*****THIS MUST BE FILLED OUT/OUR BILLING SOFTWARE DOES NOT SAVE CC INFO*****
My credit card information is as follows:

PRIMARY CARD

_____ _____
Cardholder's Name Client's Name (if different)

_____ _____
Credit Card Account Number Expiration Date

_____ _____
CCV Code Zip Code

OPTIONAL SECONDARY CARD

_____ _____
Cardholder's Name Client's Name (if different)

_____ _____
Credit Card Account Number Expiration Date

_____ _____
CCV Code Zip Code