CREDIT CARD ON FILE POLICY

At CAF therapeutic Strategies LLC, it is required to keep your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Without this authorization, a billing fee of $5 will be added to your account for any balances that we must attempt to collect through mailing monthly statement. Furthermore, an "outstanding balance" charge of 1.5 percent of the total bill will charged for each month that the bill remains unpaid.

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

I authorize CAF Therapeutic Strategies LLC to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐Amex ☐Visa ☐Mastercard ☐Discover

Credit Card Number ____

Expiration Date _____ / _____ CVV _____

Cardholder Name Signature ____

Billing Address ____

City _____________________ State_______ Zip ___________

I (we), the undersigned, authorize and request CAF Therapeutic Strategies LLC to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by CAF Therapeutic Strategies LLC.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to CAF Therapeutic Strategies LLC in writing and the account must be in good standing.

Patient Name (Print): ____

Patient Signature: ____

Date: _____ / _____ / _____