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Standard Credit Card Agreement

Payment is due at the time of each appointment, in the form of cash, check, credit, or debit card. If you prefer to pay by credit or debit card, we ask that you complete this agreement. Doing so will relieve your clinician from having to request your card at each session, thus saving time in your appointments.

Client name: _____ DOB: _____

Cardholder name as it appears on card: same as above Other: _____

Credit card number: _____ Expiration date: _____

Cardholder billing address: _____

Cardholder telephone number: _____

Cardholder e-mail address (optional): _____

For FSA or HSA cards only:

- This card is a Flexible Spending Account (FSA) or Health Savings Account (HSA) card and:
 - has no grace period and so should not be charged for any services provided after December 31st.
 - has a grace period ending ____ / ____ / ____ (no later than March 15th) and should not be charged for services provided after the grace period ends.
 - has a run-out period and should be not charged for services provided in the current calendar year (and grace period, if any) after the run-out period ends on ____ / ____ / ____.
 - I am not sure about the grace and/or run-out period; I will let CBPS know before December 31st or I will provide another form of payment promptly after December 31st.

Except as limited elsewhere on this form, I agree that Chesapeake Bay Psychological Services may charge the credit or debit card listed above for any balance due on this account at time of service or thereafter until authorization is revoked in writing. Such charges may include, but are not limited to deductibles, copays, and/or coinsurance required by my insurance policy (if any).

Please contact me first if the amount to be charged exceeds \$_____.

Please contact me first if the amount is due to an insurance denial (other than copay, coinsurance, or deductible)

I understand that I am not required to sign this agreement in order to receive services at CBPS.

Cardholder/Authorized Signature: _____ Date: _____