Chesapeake Bay
Psychological Services LLC

Standard Credit Card Agreement

Payment is due at the time of service, in the form of cash, check, credit, or debit card. It is our policy to require clients (except those with Medicaid) to keep a credit or debit card on file with us, either as the main form of payment or as a backup. This policy allows our clinicians to see clients when our receptionist is unavailable, to treat children and adolescents when parents are unavailable, and to keep appointments with clients who forget to provide payment. If your account is current and you feel the need to ask the director for an exception to this policy, please email your reasons to admin@chesapeakebaypsychological.com.

Client name:_____ DOB: _____

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

Credit card number:_____ Expiration date:_____

For your protection, after your credit card information is entered into our secure system, we have access to only the last 4 digits of your card number, and we redact and shred the original copy of this form.

Please use this card as my: ☐ main form of payment ☐ backup only

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 if the amount to be charged exceeds $_____.
☐ Please contact me if the amount is due to an insurance denial (other than copay, coinsurance, or deductible).

OR

☐ I have emailed admin@chesapeakebaypsychological.com to request an exception to the policy.

Cardholder/Authorized Signature: _____ Date: _____

☐ This client has Medicaid and so is not required to provide a credit card.