PEMBERTON & YOUNG COUNSELING

Damon Pemberton, LCSW • Krista Pemberton, LCSW • Maureen Young, LCSW

Pemberton & Young Counseling, LLC • 1345 W 9th Ave, Suite 201 • Anchorage, Alaska 99501
Phone: 907.258.8003 Fax: 907.258.8004 • info@pemyoung.com • www.pembertonandyoung.com

Patient Credit Card on File Authorization

We have implemented a policy which enables you to maintain your credit card information securely on file with our billing software, **Kareo, Inc**. In providing us with your credit card information, you are giving **Pemberton & Young Counseling, LLC** permission to automatically charge your credit card on file for your (or any other patient(s) you have listed on this form) co-pay, coinsurance and/or deductible at time of service. By signing this you authorize this agreement will remain in effect until the expiration of the credit card account and that you may revoke this form at any time by submitting a written request. Once the Patient Credit Card on File Agreement is signed and returned to our office, a member of our staff will call and input your full card number into our software.

Co-pays. Coinsurance and Deductibles*:* Co-pays, coinsurance and deductibles are due at time of the office visit.

Outstanding Balance: If your insurance provider has paid their portion of your bill [or any other patient(s) you have listed on this form] and there is an outstanding balance owed, **Pemberton & Young Counseling, LLC** will notify you via phone and/or email. If by the final billing notice, we do not receive a response from you or your payment in full, at that time, any balance owed will be charged to your credit card. A copy of the charge will be sent by email or mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

Multiple Users: This card will only be authorized for the use of the credit card holder, his/her minor(s), or any person(s) listed below.

Beginning on _____, I _____ authorize Pemberton & Young Counseling, LLC to charge co-pays, coinsurance, deductibles, and outstanding balances on my account to the following credit card:

☐ **Visa** ☐ **MasterCard** ☐ **American Express** ☐ **Discover**

Notes:

Credit Card Holder's Name:

Last 4 digits of Credit Card: _____ Expiration Date: _____ CVC: _____

Please print name(s) below of the patient(s) authorized to use this card:

Patient Full Name: _____
(Please Print)

Patient Full Name: _____

Patient Full Name: _____

Cardholder Signature: _____ Date: _____