Biological Psychiatry Center, P.C.

Credit Card on File Billing Authorization Form

Biological Psychiatry Center, P.C. is offering a secure and convenient method of payment for the portion of services that your insurance does not cover, but for which you are responsible. Your credit card information will be kept confidential and secure, and payments to your card are processed the day prior to your appointment. If you cancel your appointment without proper notice as listed on financial policy, your payment will be used towards your late cancelation or no-show charge as specified on the Financial Policy.

This credit card authorization covers payment for **Patient/Cardholder**. I, undersigned Patient/Cardholder give **Biological Psychiatry Center PC** aka **(BPCPC)** permission to charge my credit card. I understand that my credit card number will be kept on file to cover copays, co-insurance, deductibles, form/letter fees and no show/ late cancelation charges. Please review to the Financial Policy for applicable fees.

By signing this form, the Patient/Cardholder acknowledges and agrees as follows:

- Payments are due and charged the day prior to each session or by end of business the day of appointment.
- Patient/Cardholder will not be notified prior to credit card being charged.
- Patient/Cardholder will receive a Credit Card Receipt by email if card is charged (only if provided below).
- Credit card payments will appear on your statement as **BPCPC**.
- Credit card will be stored in a way that is HIPAA compliant; either in a locked file, a password protected and encrypted computer or an electronic health system.
- If the cardholder is not the client, cardholder agrees that Biological Psychiatry Center PC staff can charge this credit card in the manner described above for the client named below.
- Declined charges will incur office $10 non-payment fees (Please remember to call the office if your credit card is no longer valid. ie.. expired, lost or stolen etc…)

****This form will remain valid until Patient/Cardholder gives a 15-day written notice to cancel the authorization. Notifications can be emailed to Payments@BPCPC.COM ; by mail to Biological Psychiatry Center, PC, Attn: Billing Dept., 25869 Kelly Road, Suite A; Roseville, MI 48066 ; or by completing the "Revocation of Credit Card Authorization Form" on our website. Once we receive written notification, a staff member will email or mail letter to acknowledge cancelation. The office is not responsible for notifications not received. We ask that you ensure receipt by calling the office for verification.**

I certify that I am an authorized user of this credit card, and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Do you agree to use this card for a current or future payment plan if necessary? □ No □ Yes

- Terms to be discussed when payment plan is necessary and confirmation of term will be emailed.

Patient Name: _____ Date of Birth: _____

Card Holder's Name (as shown on card): _____

Billing Address: _____

Card Holder's Cell Phone number: _____ Home Number: _____

Card Type: □ Visa □ Master Card □ Discover □ American Express

Credit Card Number: _____ Expiration date (mm/yy): _____ /_____

CVV Code: _____ Billing Zip Code: _____ Email Address: _____

Cardholder Signature: _____Date:_____

Once Completed, this form can be mailed to our office or e-mailed to: payments@bpcpc.com