Atlantic Counseling & Consultation, Inc.
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SELF PAY PAYMENT POLICY and AUTOMATATED BILLING AUTHORIZATION

We have recently updated our policy and now require all patients to keep an active credit card on file. The credit card will be used if you do not pay at your appointment and billed the next business day.

If your account should accrue a balance, then your card will be billed on the 10th of the month.

The No Show/ Late Cancellation fee ($90) will be billed to your credit card the next business day and a receipt will be emailed to you upon request.

Patient Name: ____Today's Date: ___ /____/____

Signature of patient OR parent/guardian (if applicable): _________________________________

If you would like a receipt, please provide us with your email address (please print clearly):

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By signing below, I agree to adhere to the updated policy and I authorize Atlantic Counseling & Consultation to charge my credit card the self- pay amount(s), No show/late cancellation fees and/or any other outstanding balance.

Cardholder signature: ____

Name on credit card: ____

Please note: The credit card information will be entered into our secure online portal with Santander Bank/First Data. All credit card information will then be shredded for your security.

Visa ____ Master card_____ American Express____ Health care/Flexible spending account____

Credit Card number: ____

Exp. date: ____________