CREDIT CARD ON FILE POLICY

At Sutton Counseling, as a convenience to you and to the company, we require that you keep your credit/debit card on file for payment, for the portion of services that your insurance doesn't cover, but for which you are liable, including copays. Without this authorization, a billing fee of $5.00 will be added to your account for any balances that we must attempt to collect through mailing monthly statements. Furthermore, an "outstanding balance" charge of 1.5% of the total bill will be charged for each month that the bill remains unpaid.

Your credit card information is kept confidential and secure. Outstanding balance payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account. For Private Pay, your card will generally be charged within 1-3 days of session.

On occasion, a situation may arise which prevents you from keeping a scheduled appointment with your therapist. As a courtesy to your therapist and the office, please notify us at least ***24 hours*** in advance of your appointment if you cannot keep it. Sutton Counseling Services reserves the right to charge a fee of $50.00 for all missed appointments ("no shows") and appointments which are not cancelled with a 24-hour advance notice. These fees will be billed to the credit card on file.

I authorize Sutton Counseling Services to charge the portion of my bill that is my financial responsibility, including "no show/short-notice cancellation" fees, to the following credit or debit card:

☐ **Amex** ☐ **Visa** ☐ **Mastercard** ☐ **Discover**

Credit Card Number _____

Expiration Date _____/_____ **CVV Code** _____

Cardholder Name _____

Signature _____

Billing Street Address _____

City _____ **State** _____ **Zip** _____

I (we), the undersigned, authorize and request Sutton Counseling Services to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by Sutton Counseling Services. Also, in the event any amount(s) is/are referred to a third-party debt collection agency, I agree that in addition to any other amount(s) allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc.) I will also be responsible for a collection fee of up to 33.33% of the principal amount(s) owing as allowed by Utah Code. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility.

Patient Name (s) (Print): _____

Cardholder Name (Print): _____

Cardholder Signature: _____

Date: _____/_____/_____ Email address for receipts (Print) _____

A photocopy of this form shall be as valid as the original.