TERRAP ANXIETY AND PHOBIA CARE

COGNITIVE AND BEHAVORIAL HEALTH ASSOCIATES
A division of Julian M. Herskowitz, PhD, Psychologist, P.C.
www.anxietyandpanic.com

CREDIT CARD AUTHORIZATION

Out-of-network insurance policies:

Although TERRAP Anxiety and Phobia Care is not in-network with any insurance companies, many of the insurance companies offer out-of-network benefits that will reimburse a percentage of the costs of quality care. As a courtesy to our patients, we will submit claims for your out-of-network benefits electronically. However, most insurance companies will reimburse the patient directly. They will not send the check directly to us. Deductibles and co-insurance may apply with out-of-network policies.

Payment methods:

It is your responsibility to cover the cost at the time that services are rendered. We will accept a personal check, cash, ZELLE, VENMO (with no processing fee) or credit card payment (2% processing fee applies). Please note that we do not send invoices and that payments through these alternate methods should be made on the day of your session with your doctor. Please call our office at 631-549-8867 or email terrapbilling@gmail.com to find out more about these alternate payment methods. In order to ensure that we will be compensated in a timely manner, we ask that you provide a credit card that you authorize us to charge for your agreed upon session fee.

Cancellation policy:

All cancellations (no matter what the reason) must be made 24 hours in advance, otherwise YOU will be charged the full session fee.

I hereby authorize you to charge my credit card for professional services rendered or if in the case of assignment when checks are sent by my insurance company to me that are intended for the provider, and I fail to forward those checks within 30 days of receipt.

Credit Card information: **(please note: a 2% service fee charge of the charged amount will be added to every credit card transaction for amounts over $150, a flat $3 fee to amounts less than $150. To receive a credit card transaction receipt, please provide your email below and one will be emailed to you. The date of the session will be written on the bottom of the receipt.**

Visa ☐ Mastercard ☐ Discover ☐ American Express ☐ **Billing Zip Code: _____**

Credit Card Number: _____ Expiration Date: _____ Security Code: _____

Name on Card: _____ Signature of Card Holder *:_____

Name of patient: _____ Contact name (if different than patient) _____

Contact phone #_____ Contact email: _____

Doctor's name: _____ Agreed upon session fee rate:_____

Signature of patient * (or parent/guardian): _____ Date: _____

***By printing your name on signature field, you are confirming all information filled out above is true. This will act as your electronic signature.**