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

Although TERRAP Anxiety and Phobia Care is not in-network with all 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. It is your responsibility to cover the cost at the time that services are rendered. We will accept a personal check, cash, ZELLE, VENMO or credit card payment. In order to ensure that we will be reimbursed in a timely manner, we ask that you provide a credit card that you authorize us to charge if we do not receive payment from your insurance company within 30 days. Deductibles and co-insurance may apply with out-of-network policies.

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. To receive a receipt, please print clearly 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** ☐

Credit Card Number: _____

Expiration Date: _____ **Security Code:** _____ **Billing Zip Code:** _____

Name on Card: _____

Signature of Card Holder *: _____

Name of patient: _____

If we need to contact you regarding payment or receipts, please provide:

Contact phone #_____ **Contact email:** _____

Contact name if different than patient: _____

Date of Contract: _____ **Doctor's name:** _____

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

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