**COUNSELING ASSOCIATES**

**OF CENTRAL IOWA, PC**

**Phone: (515) 255-2224 4401 Westown Parkway, Suite 280**

**Fax: (515) 255-2228 West Des Moines, IA 50266**

**www.caciowa.com**

CREDIT CARD AGREEMENT

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize Counseling Associates of Central Iowa, PC (CACI) to charge my credit/debit card for balances due at CACI whether they are or are not covered by my insurance company, including no-show and late cancellation fees. It is my responsibility to know my insurance benefits and provide CACI with any insurance updates in a timely manner.

This authorization will be terminated when I stop receiving services and all services have been paid in full and any overpayments refunded to me. This authorization will be void when this credit card expires; a new form will be completed with my new credit card information.

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Patient or Guardian Signature Date

\_\_\_\_MasterCard \_\_\_\_Visa \_\_\_\_Discover \_\_\_\_American Express

Name on Card:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Security Code:\_\_\_\_\_\_\_\_\_\_\_\_

Your credit card information is securely protected in our HIPAA compliant practice management system with a secure network server. Receipts for any payments can be obtained by calling our office.