Lillybrook
In Times of Struggle, We Are Here

ACCT#: _____

Dear Client/Guarantor:

Lillybrook Counseling Services, like many other healthcare offices, implemented a credit card on file policy. You will be asked for a credit card number at the time of your first appointment. It can be a credit card, HSA card or FSA card. NOT A DEBIT CARD WITHOUT A CREDIT CARD LOGO ON IT. The information will be held securely to be used to pay balances on your account, such as deductibles, copays, insurance rejections and no show/late cancellation fees. Payment is due at the time services are rendered.

This will be an advantage to you, since you will no longer have to remember to bring your payment with you at each session. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and mail. This will be a benefit to everyone in helping to keep the cost of healthcare down.

This in no way will compromise your ability to dispute a charge or question your insurance company regarding how they processed your claim.

If you choose not to participate, you must maintain a zero-dollar account balance. If you make a payment with cash, debit, or check on the day of your appointment your credit card will not be charged. ***All insurance rejections and no show/late cancellation fees will be charged to your credit card within 30 days if you have an unpaid balance on the account.***

If you have any questions, please do not hesitate to speak with the clinic management. We are working diligently to be stewards of all resources and attention to keep your costs to a minimum.

Sincerely,

Lillybrook Counseling Services

Client Name: _____ Date of Birth: _____

Name of the Person who is Responsible for Payment: _____

Relationship to Client: _____

_____ I AUTHORIZE Lillybrook Counseling Services to charge outstanding balance on my account to the following credit card, FSA Card, HSA Card:

Card Type (Visa, Mastercard, etc.): _____ Exp _____

Account Number: _____ CCV_____ Billing Zip _____

Name on Card (Please Print): _____

_____ Please send me a credit card receipt when my credit card has been charged.

Email address or phone number to receive receipts: _____

_____ I DO NOT AUTHORIZE Lillybrook Counseling Services to charge my credit card. I understand that payment must be made in full at each session and that I must maintain a zero-dollar balance on the account.

Signature: _____ Date: _____

Lillybrook Counseling Services
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