



SELF PAY, BCBS & UNITED HEALTHCARE CLIENTS

COPAYS, CANCELLATIONS & NO SHOW/NO CALL POLICY:

Please be advised that your credit card below will be charged for copays or underpayments for your appointments as applicable. Cancellations and re-scheduled sessions will be subject to a full charge if appointment cancellation has **NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE**. If you are late for a session, please be aware that you may lose some of that session time.

Please remember to cancel or reschedule 24 hours in advance of your scheduled appointment. If you do not, you will be responsible for the entire cost of the session. We cannot file insurance if you do not attend a session and therefore we will charge you for the full amount that your insurance allows for a therapy session, if cancellation is less than 24 hours of the scheduled session. **You will be charged the full amount of the session for a NO SHOW to your appointment, not just your copay amount.**

For Copays, by signing this form you are authorizing Coastal Haven Counseling to charge this credit/debit or HSA card after each of your sessions going forward for as long as you continue therapy appointments with Coastal Haven Counseling, or if your insurance company does not cover or pay for your claims. This card will be charged unless an alternative form of payment is made at the time of appointment. By signing this form you are agreeing to this charge each time you attend a counseling session to be billed to your credit/debit/HSA card below.

Client Name: _____ CARDHOLDER NAME: _____

Cardholder Address: _____

Credit Card Info: (For Self-pay, BCBS United Healthcare Clients ONLY, NOT with Medicaid clients)

Card Number: _____ Exp Date: _____

3 Digit Security Code: _____ Billing Zip Code: _____

Your signature or e-signature confirms your understanding and agreement to our policy above. Thank you.

Print name: _____

Signature: _____ **Date:** _____

OFFICE ONLY: Entered into system by: _____