There may be times our office or your therapist would need to contact you re: appointments, billing, etc. Please provide us with a phone number where we may leave a message.

_____Yes Fraser Vaselakos & Associates may leave a message on the number(s) below:

Cell Phone_____ TM_____

Home Phone _____Work Phone_____

Other_____

_____Yes Fraser Vaselakos & Associates may send a billing statement to the following address*:

Street Number_____City_____Zip_____

***If statements may not be mailed to home or office address, FV will need a credit card on file**

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CREDIT CARD AUTHORIZATION FORM

Please complete the following information in order to bill your credit or debit card for therapy fees or insurance co-payments. This form will be kept in a locked file. This information should be updated in the event of any changes.

This authorizes that my card will be charged for the balance due if no payment has been made within 60 days of the last billing cycle or insurance payment on my account, if I do not attend a scheduled therapy appointment that I have not cancelled at least 24 hours in advance, if I do not pay any balance left by myself or my insurance company, or if my check is returned for any reason (plus bank fee).

If you would prefer to have your card charged for the balance due at each session please check here _____

If you would prefer to have your card charged once per month for the balance due please check here _____

If you would prefer to have your card charged for a specific dollar amount once per month please indicate the amount $ _____ and date of charge _____

Card Vendor: _____Visa _____MasterCard _____Discover _____AmerEX Credit Debit

Card Number#_____ Expiration Date: _____

Verification/Security Code: _____

Name as Printed on Card:_____

Billing Address:_____

City:_____State:_____ Zip:_____

My signature authorizes Fraser Vaselakos & Associates PC, to charge my credit/debit card on an ongoing basis for scheduled appointments either as approved by patient for regular payments and/or should account be over 60 days overdue.

_____ _____

Patient/Guardian Signature Date