HIGHER GROUND RECOVERY, INC.

(804) 363-2583

CREDIT CARD AUTHORIZATION &

NO SHOW/LATE CANCELLATION FEES, INSURANCE COPAYS & DEDUCTIBLES, THERAPY FEES

We have implemented a policy which enables you to maintain your credit card information securely on file with Higher Ground Recovery, Inc. In providing you credit card information you are granting HGR permission to automatically charge your credit card on file for you (or any other patient(s) you have listed on this form): co-payments, co-insurance, deductibles, outstanding balances, and services.

Co-payments/Co-insurance/deductibles: Co-payments, co-insurance is due at the time of the scheduled office visit. You may still choose to make your payments by check, cash, or a different credit card (different from the one of file).

Outstanding Balances: If any outstanding account balances are owed, HGR will notify you via email or USPS (US Postal Service). If the account balance is not paid in full within 5 business day of the mailing of this notice, at that time, any balanced owed will be charged to your credit card. For your notification, a copy of the charge will be emailed or mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

Missed Appointments

In order to provide you and other patients of, *Higher Ground Recovery* the best possible care, a minimum of 24 hours' notice is required to cancel or reschedule your appointments.

I, _____, understand the importance of notifying my *therapist* at least 24 hours prior to my scheduled appointment that I am not able to keep my appointment. If I am experiencing an emergency, I will provide as much notice as possible to avoid being charged the Late Cancellation fee of $75. I understand that I will be charged a No-Show fee of $125 for failing to call and failing to show for my scheduled appointment.

I, _____, give *Higher Ground Recovery* the authorization to charge my credit card $75.00 for each missed therapy session where 24 hours' notice is not provided and $125 for each missed therapy session where I fail to call and show for the appointment. This credit card will also be used for all fees that have not been paid within 60 days (unless other arrangements for payment have been agreed upon in writing between me and Higher Ground Recovery). I will be provided a receipt for all payments upon request. This card may also be used for payment of services upon my request (co-payment, deductibles, and fees).

I understand that I may revoke this agreement at any time by providing a request in writing. I am also aware that when psychotherapy services rendered by Higher Ground Recovery have ended, this form shall be shredded once I am terminated from treatment.

Patient Name (printed): _____

Patient (or Parent/Guardian)/Card Holder Signature:

_____Date: _____

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I am requesting that this card be used for payment of services (co-pay & fees): _____Yes _____No

Name on card: _____

Card Number ---------- _____

Expiration Date: _____/ _____

CCV Code: _____Street Address: _____Zip Code: _____

Email address for receipt: _____

Patient Name (printed): _____

Patient (or Parent/Guardian)/Card Holder Signature:

_____Date: _____