Turning Point
Center for Psychological and Family Growth, LLC
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CREDIT CARD ON FILE AGREEMENT

This form authorizes Turning Point Center for Psychological and Family Growth, LLC (Turning Point Center) to retain your valid credit card number on file. The form is confidential and only authorized staff will have access to your information.

Your credit card will be charged ONLY under the following circumstances:

- Turning Point Center reserves the right to charge the credit card listed below for any co-pay due at the time of service. This notice serves as your consent for any co pay charges due at the time of service.
- If you, as a patient, miss a scheduled appointment without a 24 hour cancellation notice or without rescheduling, Turning Point Center reserves the right to charge the credit card listed below. This notice serves as your consent to assigned charges for any and all no shows. *As customary, a staff member from Turning Point Center will call the phone number on file to remind you of your scheduled appointment. This reminder is usually 1-2 days prior to your scheduled appointment. It is the patient's responsibility to ensure that we have a correct, current telephone number on file.*
- If you, as a patient, request a copy of your medical record (i.e. letter written by your provider, summary of psychological evaluation, etc.), Turning Point Center reserves the right to charge the credit card listed below for any copying fee due at the time of request. This notice serves as your consent for any and all charges related to the copying of records.

Other than the conditions mentioned above, under NO circumstances will Turning Point Center charge your credit card for anything not discussed personally with you. In conjunction with HIPAA regulations, all credit card information will be kept confidentially in a secure and locked location. Only authorized staff will be able to access this information.

ACKNOWLEDGED, AGREED, & ACCEPTED:

Having read this form and talked with the staff, my signature below acknowledges that I voluntarily give my authorization and consent to providing the requested information for my credit card to be charged for the conditions listed above.

Card Holder Signature:_____ Date:_____

NAME AS IT APPEARS ON CREDIT CARD: _____

BILLING ADDRESS: _____

_____

VISA/MASTERCARD/DISCOVER/AMERICAN EXPRESS (circle one)

CARD #:_____ **Expiration Date: _____**

DO NOT COMPLETE (unless revoking credit card on file authorization):

If at any time you wish to revoke the use of this credit card for any payments you may be responsible for, please sign and date on the lines below.

Patient Signature: _____ Date: _____