denver integrative assessment

CREDIT CARD AUTHORIZATION FORM

Denver Integrative Assessment ("DIA") requests that you provide your credit card information below. If you choose to pay by credit card your credit card will be charged according to the agreed-upon payment schedule. If you choose to pay by cash or check, your credit card will only be charged if your account is past due and/or for any additional fees you and/or your minor child/ren incur such as late cancellation or no-shows fees.

□ I authorize DIA to charge my credit card $_____ (the total cost) at the first session. This credit card will be kept securely on file, but no other fees will be charged, unless additional services are requested.

□ I authorize DIA to charge my credit card $_____ (half of the total estimate) after the first session, and the balance (half of the total estimate or less, unless otherwise discussed) at the last session. This credit card will be kept securely on file and used to pay all additional fees I and/or my minor child/ren incur, if additional services are rendered as a part of this evaluation.

□ I authorize DIA to charge my credit card $_____ on the _____ (day) of each month, beginning on _____ (date) until the total balance is paid. *This option must be discussed ahead of time with Dr. Bellon.*

If your credit card does not go through, you do not have a credit card, or you do not wish to provide your credit card information, in the event your account remains past due for sixty (60) days, your account may be sent to collections. DIA reserves the right to send your account to collections, in accordance with DIA's policies and procedures; at any time after your account is considered past due.

By signing this authorization form, you agree to notify DIA of any changes to your credit card information such as a new expiration date or when your credit card has been cancelled, lost, stolen, or revoked. A new form must be submitted if information such as the list of authorized users and the credit card account's expiration date is amended.

DENVER INTEGRATIVE ASSESSMENT only accepts: VISA, MASTERCARD, DISCOVER

Type of Credit Card: Visa ___   MasterCard ___   Discover ___

Name on Credit Card: _____

Credit Card Number_____

CCV Code: _____   Expiration Date :_____

Card Holder's Full Address, including zip code (the mailing address for your Credit Card statements):

_____

_____

This credit card authorization form will remain in effect and on file at DIA unless revoked in writing or until the therapeutic relationship is terminated, at which time, authorization to charge your credit card will be revoked, unless an outstanding balance remains on your account after termination. DIA will not share your credit card information with any third-party without your consent. Your credit card information will be kept confidential.

Please check one:

□ Card Holder is the client (or parent/legal guardian) receiving services from DIA.

      I hereby authorize DIA to charge the above credit card number for payment of the evaluation fees I or my minor child/ren incurs, which shall include late or past due fees or fees related to cancellations or no-shows. I understand that my credit card will be billed in accordance with the authorizations listed above.

      _____   _____

      Client/Parent/Legal Guardian Signature   DATE

□ Card Holder is a third-party payer for the client receiving services from DIA.

      I_____, hereby authorize DIA to charge the above credit card number for payment of the evaluation fees (Client)_____ incurs, which shall include late or past due fees or fees related to cancellations or no-shows. I understand that my credit card will be billed in accordance with the authorizations listed above. I understand as a third-party payer that I am only entitled to receive information concerning payment and that this Credit Card Authorization Form does not authorize me to receive any confidential and protected information about Client beyond payment.

      _____   _____

      Third-Party Payer's Signature   DATE

      I, _____, authorize DIA to communicate with the above Third-Party Payer solely as it may relate to payment for services I receive from DIA.

      _____   _____

      Client's Signature   DATE