Unwritten Endings, LLC

10075 Bergin Rd. Suite C
Howell, MI 48843
https://youthandfamilytherapy.com/

Credit/Debit/Health Account Card Authorization Form

This form serves as an authorization to input credit/debit/health account card information into our secure system and charge it when an account balance exists. It will remain in effect until the client/parent/legal guardian or cardholder cancels it in writing.

The following are examples of charges that Unwritten Endings would run on this card: co-payments, deductibles, document preparation/report-writing fees, costs for attendance at collaboration meetings, late cancel and no-show fees, returned check fees, court attendance, etc.

If indicated on the client's Insurance Checklist or Explanation of Benefits that there is an unmet deductible, payment for this deductible will be processed at the time of each session and for any sessions already completed that have went to the deductible. It is the client/parent/legal guardian's responsibility to let Unwritten Endings know when a deductible has been met so that payments do not continue to be collected.

If a credit is on the client's account once the deductible has been met, a refund can be issued following payment from insurance or the credit can remain on file with Unwritten Endings to use toward ongoing fees.

To use this card to pay for client balances, a copy of the cardholder's ID will need to be placed on file.

Name of client: _____

Name of cardholder: _____

Last 4 digits of card number: ___ ___ ___ ___

Card's customer service number: _____

Cardholder's address: _____

Cardholder's phone number: _____

By signing this form:

- I authorize Unwritten Endings to charge my credit/debit/health account card for professional services, regarding the client listed above, up to 24 hours before the scheduled appointment.
- I certify that I am an authorized user of this card and that I will not dispute payments made with my credit/debit/health account card company, provided the transactions correspond to the terms indicated in this authorization form.

Cardholder's authorizing signature: _____ Date: _____

Call/Text: (810) 444-2484 Fax: (810) 272-4991
Email: contact@unwrittenendingsllc.com

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- I verify that the above information is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if card payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred.
- I understand by signing this form, that if no payment has been made on my overdue balance within 30 days, it will go to an outside collection agency or attorney, and I will be responsible for the cost of collection services up to 25% of the balance due, along with reasonable attorney fees and court costs incurred by Unwritten Endings.
- I consent to Unwritten Endings contacting the listed cardholder on my behalf, and vice versa, regarding any financial balances, declined charges/ insufficient funds, expiration or change in information, invoices/receipts, and any other matters related to payments owed to Unwritten Endings.
- *I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws.*
- *I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.*
- *I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and is no longer protected by federal confidentiality laws or Unwritten Endings. Unwritten Endings will not be held liable for information disclosed to another party per the client's request.*
- *I understand that this authorization is voluntary, and I may revoke this consent at any time except to the extent that action has already been taken pursuant to the authorization.*
- *I have been informed what information will be given, its purpose, and who will receive the information.*
- *I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization and Unwritten Endings will not base my treatment or payment on whether or not I provide authorization for the requested use or disclosure.*

Client/Parent/Legal Guardian's signature: _____

Date: _____