Phone: 216-252-1399
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14538 Grapeland Avenue
Cleveland, Ohio 44111

CREDIT CARD/DEBIT CARD PRE-AUTHORIZATION FORM FOR PSYCHOLOGICAL TREATMENT, MISSED APPOINTMENTS, AND PAST DUE STATMENTS

We require your credit card information for several reasons:

1) If you miss more than one appointment without calling 24 hours in advance, then we charge your card the missed appointment fee of $75.00. This fee cannot be submitted to insurance.
2) In the event that you have an outstanding balance past 120 days, then we will notify you in writing that your card will be charged for the outstanding balance within 15 days if you do not call our billing department to make partial or full arrangements for payment.
3) If you have co-pays or are paying out-of-pocket, we can keep your credit card information on file and charge it at the time of each session. This is optional.

Please complete the following:

I authorize Daily Behavioral Health, Inc. to keep my signature on file and to charge my Visa, Mastercard, or Discover account for recurring charges of $75.00 for any missed appointment in which I have not called 24 hours in advance to cancel and for any outstanding balances past 120 days. I realize I will only be charged for outstanding balances past 120 days if I have not made any payment arrangements with the billing department.

I authorize Daily Behavioral Health, Inc. to keep my signature on file and to charge my Visa, Mastercard, American Express, or Discover account for an initial or reoccurring charge of $_______ per visit and/or a one time charge of $__________ for previous services rendered. **(If you choose not to use this option, please put $0.00 for the amount.)** If you have any questions, please ask the receptionist or your therapist.

I understand this form is valid for one year unless I cancel the authorization in writing. I promise not to dispute charges ("charge back") for sessions I have received or that I have not cancelled 24 hours prior to a scheduled session. I further authorize Daily Behavioral Health, Inc. to disclose information about my attendance/cancellation to my credit card issuer if I dispute the charge.

____
Client Name

____
Cardholder Name

____
Cardholder Billing Address City State Zip

_______________________________________ _____________________
Account Number Expiration Date

_______________________________________ _____________________
Cardholder Signature Date