Tompkins & Associates
Licensed Clinical Psychologists

Specializing in the Treatment of Children and Their Families

Credit Card Authorization Form

Tompkins & Associates requires that all patients have a credit card on file. Although our office policy is to collect co-payments and deductibles as services are incurred by cash or check, this card on file conveniently assists in the collection of patient responsibilities for fees that are past due 60 days. Account numbers are kept secure. You may also revoke this agreement in writing at any time. Your cooperation is much appreciated.

Type of Card:

☐Visa ☐MasterCard ☐American Express ☐Discover ☐FSA/HSA

Is this a Flex spending (FSA) or Health savings (HSA) card?

☐ Yes ☐No

Credit Card Information: (Please be sure to complete all sections.)

Card Holders Name: ____

Credit Card Number: ____

Expiration Date: ____

3 Digit Security Code on back of card (4 digits on front of AmEx): ______________

Billing Zip Code of Credit Card: ____

I understand that by signing below, I am authorizing Tompkins & Associates to charge my credit card for balances 60 days past due. These balances may include unpaid co-pays, co-insurance amounts, deductibles, and/or charges for missed/late cancelled appointments. I understand that Tompkins & Associates can provide me a statement as well as a receipt for any charges that are applied to the credit card upon request. Tompkins and Associates will contact me if my card is declined or expired should I fail to update this information.

____ __________________________

Card Holder’s Signature Date

____

Patient’s Name