The Jones Center for Children's Therapy and Assessment
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Authorization to Maintain and Debit a Debit/Credit Card on File

I, _____, authorize JCCTA to debit the debit/credit card indicated below for all charges accrued to the account of _____, Date of Birth _____.

_____ I understand and agree denial of any transaction for payment of any accrued fee(s) to this card is still my responsibility. I acknowledge payment of all assessed fee(s) is due by the date of the next scheduled appointment.

_____ I understand and agree fees for services rendered are dependent on the applicable insurance policy on the date services are rendered, if insurance benefits are being used. These fees may relate to a copay, coinsurance, and/or a deductible.

_____ I understand and agree this card will, at the time of occurrence, be charged $50.00 for any missed therapy appointment or standing therapy appointment not cancelled with 24 business hours advance notice.

Card Information Debit or Credit (circle one)

_____ Number

_____ Expiration Date

_____ Security Code

_____ Name as it appears on card

Cardholder Information

_____ Name

_____ Date of Birth

_____ Billing Address

_____ Email address

_____ Telephone/Cell Number

_____ Authorized Signature

_____ Date

Please attach a copy of your driver's license to this form.