InsightCounseling
SERVICES OF GREATER LANSING, LLC

Credit Card on File Agreement

Insight Counseling of Greater Lansing, LLC has implemented a credit card policy: At check in, your credit card information will be obtained and kept securely until your insurance(s) have paid their portion and notifies us of the balance due, if any. At that time, you will be sent a statement which you will have 30 days to pay. After 30 days, if the bill remains unpaid, we will bill your credit card. Your ability to dispute a charge or question your insurance company's determination of payment will remain unchanged.

Co-Pays: Co-Pays are still due at the time of service. The card on file will be used to collect copays at the time and date of sessions.

Late Cancellation Fees/No-shows: Insight Counseling Services of Greater Lansing charges $75 per occurrence for no-show fees/late cancellations (less than 24 hours). The card on file will be used to collect these fees, if applicable.

Your ability to dispute a charge or question your insurance company's determination of payment will remain unchanged. If you have any questions about our policy, please do not hesitate to ask.

By signing below, I authorize Insight Counseling Services of Greater Lansing, LLC to keep my signature and my credit card information securely on-file in my account. I authorize Insight Counseling Services of Greater Lansing, LLC to charge my credit card for any outstanding balances when due.

If the credit card that I give today changes, expires, or is denied for any reason, I agree to immediately give Insight Counseling Services of Greater Lansing, LLC a new valid credit card which I will allow to be charged over the telephone. Even though Insight Counseling Services of Greater Lansing, LLC is not processing the new card in person, I agree that the new card may be used with the same authorization as the original card I presented.

Circlet One: Visa MasterCard Discover American Express

Client Name (Print): _____ DOB: ____/____/____

Name on Card (Print): _____ CVV_____

Credit Card Number: _____ Exp. Date: ____/____

Card Holder's Address (Street, City, State, Zip) _____

Please fill out information below for any other person(s) you authorize this credit card for:

Client Full Name (Print): _____ DOB: ____/____/____

Client Full Name (Print): _____ DOB: ____/____/____

Credit Card Holder's Signature: _____ Date:_____

	Please check the box if you prefer not to receive a statement and would like us to bill your credit card immediately for any balances due after the processing of your insurance.