Bridges Spectrum Therapy LLC.
13019 Pauline Drive
Shelby Township, Michigan
Telephone +1 586 207-9255
www.bridgesspectrum.com

Automatic Payment Authorization

Unless other payment arrangements are made in advance, our office requires that a credit card be kept on file for payment of any co-payment, coinsurance, deductible, attendance fee, or other charge that may not be covered by health insurance. This form will be kept confidential and only authorized staff has access to the information.

Child's Name: _____ **Date:** _____

Name on Card: _____ **Telephone:** _____

Billing Address: _____

_____

Email Address: _____

- ☐ American Express
- ☐ Care Credit
- ☐ Discover
- ☐ Mastercard
- ☐ Visa
- ☐ Other

Credit Number: _____

Expiration Date: _____ **Code:** _____

I certify that I am named on the above credit card and acknowledge and authorize Bridges Spectrum Therapy to charge the above credit card account for any co-payment, co-insurance, deductible, attendance fee, and/or other charges that are not covered by my health insurance carrier. I acknowledge that my card will be run at the end of each appointment (or as soon as possible after) for known co-payment or coinsurance amounts, and if payment is not received within thirty days after I receive a statement for other outstanding balances. I agree to receive billing statements, invoices, collections, and receipts via the email and telephone number that I have provided above. If I am a self-pay client, I authorize full payment at time of service. I agree to update any information regarding this credit card account.

_____ _____
Signature Date