BELL CENTER FOR ANXIETY AND DEPRESSION

CREDIT CARD AUTHORIZATION FORM

Because there are times that clients may not pay at the time of sessions (e.g. forgotten checkbooks, minors coming to therapy without parents, etc.), the Bell Center for Anxiety and Depression asks that you provide a credit card number to keep on file, to which any unpaid balance may be charged at the time services are rendered. Charges for individual sessions are outlined below. If credit card information is not provided, then a deposit equivalent to the charge for a single session will be required prior to the first appointment.

Schedule of Charges for Bell Center for Anxiety and Depression

CPT Code*	Session Length	Fees		
		Dr. Bell	Staff Clinicians	Post-Graduate Associates
90832	30 minutes	$150	$125	$105
90834	45 minutes (standard session)	$215	$175	$150
90837	60 minutes	$260	$215	$185
90837	75 minutes	$325	$265	$225
90837	105 minutes	$430	$350	$300
90846/ 90847	Family Therapy (with or without patient present)	See individual therapy fees		
90853	Group Psychotherapy (any length)	Varies by group		
90791	Diagnostic Evaluation	See individual therapy fees		

Acceptance of Patient Charges Statement:

I, _____, understand that I am responsible for the fee for each session at the time of appointment. I further understand that the Bell Center for Anxiety and Depression will charge my credit card for the *full* cost of any late/missed appointments that I do not pay for otherwise at the time of the late/missed appointment. I hereby authorize the Bell Center for Anxiety and Depression to keep my signature on file and to charge my credit card as outlined above, for late/missed appointments, or for appointments where payment is not otherwise rendered. I understand that this form is valid for one year unless I withdraw the authorization through written notice to the health care provider.

_____
PATIENT NAME

CREDIT CARD TYPE:

MASTERCARD VISA

_____
CREDIT CARD NUMBER

DISCOVER AMERICAN EXPRESS

_____ _____
EXPIRATION DATE V-CODE

_____ _____
EXACT NAME AS IT APPEARS ON CARD RELATIONSHIP TO PATIENT

_____
BILLING ADDRESS

_____
CITY STATE ZIP

_____ _____
CARDHOLDER SIGNATURE TODAY'S DATE