Assurance
Healthcare & Counseling Center

Billing Information and Authorization

Membership information

Name(s) and birthdate(s) of members to be billed via this account:

_____ Date of Birth_____

_____ Date of Birth_____

_____ Date of Birth_____

_____ Date of Birth_____

_____ Date of Birth_____

_____ Date of Birth_____

Membership start date: _____ *(also your billing due date)* **Total per month:** _____

Do you have medical insurance? ☐ Yes ☐ No

*(If yes, **please bring your ID card** to your first visit so that we may expedite referrals and outside lab testing)*

Billing Information

Billing frequency: ☐ Annually ☐ Monthly ☐ Other: _____

Option A: Credit Card or Debit Card

Name on Card:

Card Type: ☐ Visa ☐ MasterCard ☐ American Express Security Code: ____ ____ ____

Card Number: Exp. date: _____/_____

Card billing address:

Option B: Automatic Funds Transfer

**Please note that it takes approximately three days from the payment processing date before the charge posts to your bank account.*

Name on Account:

Bank name: Account type: ☐ Checking ☐ Savings

Account number:

Bank Routing Number:

(Please attach a voided check to this form)

Authorization

Your monthly care fee covers the services specifically described in the Assurance Healthcare & Counseling Center Patient Services Guide. At times, however, your care may require durable medical supplies, medications, labs, x-rays or other third-party services that are not covered by your monthly membership fee. To streamline your appointment check-out, please note that by providing the above billing information you authorize Assurance Healthcare & Counseling Center to automatically charge your card or draw on your bank account for any incidental items are charged at or near our cost and will be discussed with you in advance.

- By signing below, I hereby authorize Assurance Healthcare & Counseling Center (AHCC) to contact me using the information I have provided above. By signing below, I hereby authorize AHCC to initiate charges to my credit card, debit card or bank account for my recurring membership fee and any incidental fees that I incur or have incurred on my account since my last billing date. I understand that the transaction amount is the total of my care fee plus the care fees of any individuals on my account.
- This Authorization to perform periodic charges to my credit card, debit card or bank account will remain in full force and effect until AHCC has received written notification from me of its termination in such time and in such manner as to afford AHCC and my financial institution a reasonable opportunity to act on it.
- I understand that my participation in AHCC is continuous and that by signing below, I authorize recurring credit/debit card charges.
- I understand that a $25 fee will be charged to me for declined credit, debit card or automatic funds transfer transactions that are not honored.
- I understand that there is a **six (6) month minimum membership requirement**. If I terminate my membership within the first six (6) months, I understand that **early termination fees may apply**.

Account Holder Signature: _____ Date: _____

Account Holder Printed Name: _____ Birthdate: _____

Office use only

Patient number: Date:
