Assurance
Healthcare & Counseling Center

Employer Billing Information and Authorization

Company Name:_____

Membership start date (typically the 1st of the month): _____

Administrator Name: _____

Phone Number: _____

Email Address: _____

Billing Information

Invoices are emailed on the 1st of the previous month they are due (these are draft invoices, and may be modified prior to the due date in the case of adding or removing employees). The method of payment on file will automatically process on the invoice due date (the 1st of the month) unless otherwise requested. Invoices and receipts of payment will be sent to the email address listed above.

To add additional authorized users / administrators, please email groups@assurancehealth.org.

Adding or removing employees from your group plan must be communicated in writing by an authorized user by 3pm of the last business day of the month prior to the invoice due date. The simplest way to communicate changes is by emailing groups@assurancehealth.org.

Payment Information

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

Each monthly invoice includes a monthly care fee for the employees and/or family members whose information is provided to us via our registration forms. Our relationship with you as the employer is as a third-party payer, where you are simply paying a membership fee on behalf of your employees. The care we provide is done through individual contracts we hold with each employee and/or family member.

The monthly care fee covers the services specifically described in the Assurance Healthcare & Counseling Center Patient Services Guide (found on our website). At times, employees care may require services or products provided by our clinic (such as durable medical supplies, medications, labs, x-rays or other third-party services) that are not included in the monthly care fee. Unless we are given written authorization by you, the employer, all employees will be held responsible for any additionally incurred charges outside of the monthly membership fee.

- 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 employee's recurring membership fees. I understand that the transaction amount is the total of all care fees of any individuals and/or families on my account.
- This Authorization to perform monthly 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, or bank account charges.
- I understand that a fee (as determined by our financial institution) will be charged to me for declined credit/debit cards, returned checks, or automatic funds transfer transactions that are not honored.
- I understand that there is a **six (6) month minimum commitment required for my business group.** If I terminate my employer account within the first six (6) months, I understand that **early termination fees may apply**. *This agreement applies to the business account as a whole and not to individual memberships.*

Authorized Signature: _____ Date: _____

Printed Name: _____