



## Individual, Couple & Family Psychotherapy

Serving Belle Plaine, Burnsville, Cologne, Eden Prairie, & Glencoe

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[www.thejonascenter.com](http://www.thejonascenter.com)

# Pre-Authorized Healthcare Payment Form

The Jonas Center requires the following information in order to assure payment, keep overhead as low as possible and protect your credit. If you choose not to provide this information, then payment is expected at the time of service.

Client Name: \_\_\_\_\_ Cardholder Name: \_\_\_\_\_

I authorize The Jonas Center to keep my signature on file and to charge my Credit/Debit Card for professional services as follows:

1. for insurance copays and/or deductables. \_\_\_\_Yes, or \_\_\_\_No, I will pay at the time of service or when billed.
2. for the balance of fees not paid by my insurance company if my bill becomes overdue unless another arrangement has been made (Fees are determined after the contracted rate adjustment, if applicable.),
3. for failed and late cancelled appointments unless another arrangement has been made.

Type of Card: \_\_\_\_Visa \_\_\_\_Mastercard

Account # \_\_\_\_\_ Expiration Date: \_\_\_\_\_ CVV2: \_\_\_\_\_  
*3 digits on back of card*

This is a: \_\_\_\_Credit/Debit Card  
\_\_\_\_Health Savings Acct or FlexPlan Card

### CARDHOLDER'S BILLING ADDRESS FOR CREDIT CARD STATEMENTS

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cardholder Signature: \_\_\_\_\_ Date: \_\_\_\_\_

