Individual, Couple & Family Psychotherapy
Serving Belle Plaine, Burnsville, Cologne, Eden Prairie, & Glencoe

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320.864.6139 | 952.361.9700 | fax: 320.864.6130
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 deductibles. _____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:_____