



837 S. Lapeer Rd, Ste 205, Oxford MI 48371

CREDIT CARD ON FILE POLICY

At GLIO Counseling Group, we require keeping your credit or debit card on file as a convenient method of payment for the portion of services for which your insurance doesn't cover, but you are liable. Your credit card information is kept confidential and secure. Payments to your card are processed **only** after the claim has been filed and processed by your insurer, and the insurance portion of the claim has been paid and posted to the account.

Cancellation Policy

Sessions must be cancelled at least 24 hours in advance. I authorize GLIO Counseling Group to charge a \$50 late cancel/no show fee.

I authorize GLIO Counseling Group to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

Amex Visa Mastercard Discover

Credit Card Number _____

Expiration Date ____/____/____ CVC Code _____ Zip Code _____

Cardholder Name _____

Signature _____

As the undersigned, I authorize and request GLIO Counseling Group to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

If patient responsibility portion of your charges (including charges applied to your deductible, coinsurance and co-pay) is not paid within thirty (30) days following receipt of the financial responsibility statement, then we will bill your stored credit card for the outstanding balance due.

This authorization relates to all payments not covered by my insurance company for services provided to me by GLIO Counseling Group.

This will remain in effect until I cancel this authorization.

Patient Name (Print): _____

Patient Signature: _____

Date: ____/____/____