Lori B. Bohnert, MS, LMHC
2973 West SR 434
Suite 400
Longwood, Florida 32779
Office (407)449-0751

Credit/Debit Card Payment Consent Form

Dear Clients,

Due to the increasing complexity of health insurance, we ask that you secure a credit/debit card to be kept on file in a secure location in your file. Copays/coinsurance and deductibles are due at the time of your appointment as required by your insurance company. We will submit claims to your insurance carrier on your behalf an only after the claim has been processed and patient responsibility is verified will your card be charged for the balance.

Client Name____

Name on Card if different than client:______________________

Card Number____

Expiration Date____________ Billing Zip Code_______________

Cvv code___________

*all cards will be run as credit if not present.

I authorize Lori Bohnert, MS, LMHC to charge my credit/debit card for professional services on the date of my scheduled appointment for any copays/coinsurance/deductibles. I authorize outstanding balances to be charged after insurance processes my claims.

I authorize and understand that I may be charged a LATE CANCELLATION fee of $75.00 if I fail to give at least 24 hour notice prior to cancelling my appointment. I authorize and understand that I maybe charged a NO-SHOW fee of $75.00 if I fail to show for my scheduled appointment.

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Signature of Responsible Party