Ryan Long, LICSW

STATEMENT OF FINANCIAL RESPONSIBILITY

I,_________________________, understand that it is a policy of the practice to retain credit card information on all clients in order to manage collections. By listing the contact information below, I am identifying the person who holds financial responsibility for payment.

AUTHORIZATION FOR CREDIT CARD USE

Please read Options A and B. Sign and date the option of your choice.

OPTION A
I authorize Ryan Long, LICSW, to use the credit card information that I supply below to charge my credit card for services provided by Ryan Long to me or my child. I understand and accept that my credit card will be charged at the beginning of each month upon completion of services rendered during the prior month.

____ Signature

____________________ Date

OPTION B
I authorize Ryan Long LICSW, to use the credit card information that I supply below to charge my credit card for services provided through Ryan Long, LICSW, to me and/or my child ONLY IF AND WHEN MY PAYMENT BALANCE BECOMES PAST DUE per the Therapy Agreement that I have signed.

____ Signature

____________________________ Date

Please provide all of the information requested below:

____ Credit Card Type and Number (Visa, Mastercard, or Discover)

___________________________ Client's Name

_____________________________________ Name of Credit Card Holder

___________________________ 3-Digit Security Code

_____________________________________ Billing Address (Street, City, Zip Code)

____________________________ Credit Card Expiration Date

By signing this form, I understand that Ryan Long, LICSW will send monthly statements with detailed information about services, charges, payments, and appropriate information for out-of-network insurance reimbursement, if requested and applicable. By refusing to sign this form, I understand that I must pay for services at the time that they are rendered and contact Ryan Long to discuss pre-payment options.