

Payment Information

Client Name: _____

'Play It Out! PLLC requires a credit card on file for ease of billing for late cancellations (within 48 hours), no shows, copays and unpaid balances. This saves me time and effort, and enables me to focus more of my energy on my therapy work. You will be notified before you are charged each time.

* **Credit Card** type (Circle): Visa / MasterCard / Other: _____

Name on Card: _____

Card number: _____

Zipcode: _____ Expiration Date: _____ CVV (3 or 4 digits): _____

* **Primary Payment Method** (Circle): Insurance / Self Pay (*Credit Card / HSA / Check / Cash*) / Other

If primary payment method is insurance:

Insurance plan name: _____ ID# _____

Group # _____ Copay? _____

Primary Holders Name: _____ Primary Holder DOB: _____

Primary Holder's Address: _____

Primary's Phone Number: _____ Primary Employer: _____

Primary Holder's relationship to client (circle): Self / Child / Spouse / Parent / Other: _____

I authorize Play It Out! PLLC to charge my credit card for any incidental expenses throughout the course of therapy.

If insurance is the payment method of choice, I authorize Play It Out! PLLC to release the information necessary about my care to bill my insurance.

I would like Superbills for reimbursement from my Insurance Company.

I choose to receive Credit card receipts and Superbills with confidential information via unencrypted email.

Signature of client /parent/guardian

Printed name

Date