Biofeedback and Family Therapy Center
Steven C. Kassel, MFT, BCB, BCN
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Dear Patients:

Effective November 1st, 2003, I will be implementing a new requirement in this office. We are requiring all patients to fill out a credit card form that automatically authorizes me to run any **DELINQUENT BALANCES** on your credit card.

I am forced to put this into practice as it seems the number of patients not paying their statements in a timely manner has risen dramatically and some health plans change their mind about coverage or the amounts they will pay, despite the patient being given an authorization number for treatment. It is very costly to re-bill over and over again.

I realize that some of you will be resistant to this policy Please rest assured that your number is confidential and will be available only to myself and not to any billing service and will be locked in a secure place when I am not in my office. After your 3rd party payer (Insurance, EAP, Managed Care Company, HMO) has paid or sent us a denial, we will send you a statement within 30 days. As long as your bill is paid in a 30 day time frame, **WE WILL NEVER HAVE TO USE YOUR CREDIT CARD.**

If you have a special circumstance, and would like to speak with me please feel free to do so. We can go over this and other payment options. Please note that many businesses require this policy. Daycare centers, hotels and many business' require credit card information right up front.

Thank you in advance for your understanding as I am working in creative ways to keep your health care costs as low as possible.

I AUTHORIZE STEVEN C. KASSEL TO CHARGE MY CREDIT CARD IN THE EVENT THAT MY ACCOUNT BECOMES DELINQUENT OR IF MY CHECK IS RETURNED FROM THE BANK.

CREDIT CARD COMPANY: _____

CREDIT CARD NUMBER: _____ - _____ - _____

EXPIRATION DATE: _____/ _____ /_____ 3 DIGIT CODE: _____ _____ _____

STREET ADDRESS NUMBERS: _____ ZIP CODE: _____

NAME AS IT APPEARS ON THE CARD: _____

SIGNATURE: _____