CLEVELAND
Hearing & Speech
CENTER www.chsc.org

Cleveland • Broadview Heights • Westlake • Lyndhurst

216-231-8787

Automatic Payment Consent Form

Client Name:_____ DOB:_____

Insurance Provider:_____

It is CHSC's policy that clients complete the automatic credit card consent form. Clients will be charged weekly for any co-pays, deductibles, and any other co-insurance amounts due for the session(s) that week. Your card will only be charged if you or your child attends the session that week. **Your credit card information will remain confidential and will be available to Client Care Coordinators and Billing Department personnel only.**

_____ I authorize Cleveland Hearing & Speech Center (CHSC) to apply charges to my credit card for co-pays, deductibles, and any co-insurance amounts due for services provided.

❍ Visa ❍ Mastercard ❍ Discover

Credit Card #: Expire Date: CCV:

_____ _____ _____

Name on Card: Zip Code:

_____ _____

- **If my credit card is denied, CHSC will mail me an invoice for the total amount due.**
- **If your credit card information changes, please notify the Client Care Coordinator as soon as possible so we may update your account.**
- **All Credit cards are subject to a 3% surcharge fee. Debit Cards are not subject to this fee.**

Responsible Party Name:_____

_____ _____

Responsible Party Signature Date

Completed form may be returned to:
autocc@chsc.org or brought to next appointment.