PSYCH
Howland Psychiatry/Psychotherapy
www.howland-assoc.com
PHONE 413-664-4600
FAX 413-664-4660

ALL CO-PAYMENTS ARE EXPECTED TO BE PAID AT THE TIME OF YOUR APPOINTMENT UNLESS OTHER ARRANGEMENTS HAVE BEEN DISCUSSED AND AGREED UPON IN ADVANCE.

Your health insurance may reimburse us for your visit however, you are responsible for any deductible, copayment or balance applicable to your individual policy. Howland Associates is now asking all patients/clients to submit a credit card authorization sheet as follows. In the unlikely event that you have a balance owed for more than 60 days we will charge the overdue amount to your account and notify you of the charge.

CREDIT CARD AUTHORIZATION FORM

To be used only for bills 60 days overdue unless you specify otherwise below.

Name: _____
(Please print)

Client Name: _____
(Please print)

Type of Credit Card: **VISA MASTERCARD DISCOVER DEBIT**

Card #: _____

Exp. Date: _____ **Security Code:** _____

Billing Zip Code _____
(Address credit card bill is received)

Signature: _____

If you would like us to bill your card monthly, please sign below:

Please notify us if your credit card information changes.

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BILLING AND PAYMENT FEES

Payment is expected at the time of your appointment unless other arrangements have been discussed and agreed upon in advance. Your health insurance company may reimburse for your psychotherapy, however, you are responsible for any deductible, co-payment or balance applicable to your individual policy. Howland Associates asks all clients to submit a credit card authorization sheet. In the unlikely event that you have a balance owed for more than 60 days. Howland Associates will charge the overdue amount to your account and notify you of this charge by mail.

CREDIT CARD AUTHORIZATION FORM

To be used only for bills <u>60 days</u> overdue unless you specify otherwise below.

NAME: _____
(Please print)

CLIENT NAME: _____
(If different from credit card name)

TYPE OF CARD; VISA___ MASTER ___ DISCOVER ___ DEBIT ___

CREDIT CARD #: _____

EXPIRATION DATE: _____SECURITY CODE: _____

BILLING ZIP CODE: _____

SIGNATURE:_____

If you want Howland Associates to bill your credit card monthly, please sign below:

_____
Signature

If your credit card changes, please let us know. Thank you.

John S. Howland, M.D. Shahrzad Yamini, M.D. Carol Vivori, N.P Morton Broch, Ph.D Ashley Benson, LICSW
Erica Forrest, MSW, LICSW Marie Wargo, Psy. D, LMHC, CADAC James Borowski, MEd, LMHC, CRC
Donna Rempell, LICSW David B. Dawson, LICSW Claire Cabiles, LICSW

THERAPIST SIGNATURE: _____