Bethel Olentangy Psychological Services
An Association of Independent Practitioners
4949 Olentangy River Road Columbus, OH 43214
Email: admin@bethelolentangy.com
Phone: (614) 451-6606 / Text: (614) 450-2927 / Fax: (614) 451-6606

Patient Name:_____ Patient Date of Birth:_____

The ***cardholder*** agrees to the use of the credit card number (listed below) for fees associated with appointments for the above-named client at the office of Bethel Olentangy Psychological Services. The cardholder understands this may include fees for missed appointments and other fees that are not billable to insurance. This agreement is binding until written notice canceling the agreement is received by the office. Termination will not be effective for previously incurred charges. If there are any changes in the information below, I agree to update the practice immediately.

If Applicable:
I am responsible for_____% of my child's medical expenses. I agree to keep my portion of any medical expenses for my child up to date. I agree that if the other parent involved in my child's medical care defaults on their portion of the expenses accrued at this office, I will be held responsible, and this card may be charged. I understand that Bethel Olentangy Psychological Services requires payment up front for services rendered.

Credit Card Information	
Card Type: Visa ☐ Mastercard ☐ Discover ☐ American Express ☐ HSA ☐	
Credit Card Number:	Expires:
Name of Cardholder:	CVV Code:

_____ _____
Cardholder Signature Date

_____ _____
Patient Signature Date
(If applicable and if patient is not the cardholder)

FOR OFFICE USE ONLY
Clinician:
Form reviewed by office staff:
Patient is under 18: