Kerry J DeVries Inc
224 707-0847

Credit Card on File Agreement

Insurance Information

Name of Insurance Company: _____
Name of Insured: _____
Insured Person's Relationship to Patient: _____
Insured Person's Date of Birth:_____
Policy Number: _____
Mental Health Claims Phone: _____

Credit Card Information (Required of ALL clients regardless of billing or payment arrangements)

Cardholder's Name: _____
Card Type: Visa Discover Master Card :_____
Account Number: _____
Expiration Date: _____
Verification Number (three numbers of back of the card): _____
Zip Code for Card's billing address: _____

I authorize Kerry J DeVries Inc. to keep my credit card on file and charge my credit card for the cancellation fee ($160.) for any appointment missed or cancelled with less than 24 hours' notice as well as for any outstanding balance upon termination. I understand that this authorization is valid for one year unless I cancel the authorization through written notice to Kerry J DeVries Inc.

Printed Name: _____

Signature of Patient or Legal Guardian: _____

Date: _____

It is not our policy to carry balances with our clients. Payment is due at the time of service. Unless prior arrangements have been made, if for any reason you should have a balance that is due past 60 days, we will automatically charge the balance to your credit card.
Any missed sessions or cancellations without a 24 hour notice will be charged to your designated credit card as well.

Kerry J DeVries Inc
1580 N Northwest Highway
Suite 125
Park Ridge IL 60068