# Payment Method Authorization

This form authorizes charges to a payment method provided separately. Do not write card information on this form.

## Client and Payment Method Information

Client name

Date of birth (MM/DD/YYYY)

Name of payment method owner

Relationship to client

## Payment Authorization

I authorize Robert Romano, LCSW, LLC to charge the payment method that I provide separately for fees I owe under the fee and cancellation policies discussed with me. This may include consultation fees, psychotherapy or coaching session fees, and applicable late-cancellation or missed-appointment charges.

The fee structure and any applicable charges will be discussed in advance. If I believe a charge is incorrect or have a billing question, I will contact the practice so the matter can be reviewed and resolved by both parties.

This authorization remains in effect until it is revoked in writing. I will notify the practice promptly if my payment information changes and will contact the practice with any questions or concerns regarding an invoice.

## Good Faith Estimates

Under the federal No Surprises Act, clients who are uninsured or who do not plan to use insurance are entitled to a Good Faith Estimate of expected charges when services are scheduled or upon request. Please contact me with any questions or to request an estimate.

# Payment Method Authorization

*continued*

## Out-of-Network Benefits

I understand that Robert Romano, LCSW, LLC is an out-of-network provider with all insurance carriers. I am responsible for understanding my plan's out-of-network benefits and for payment of services regardless of whether my insurance company reimburses me.

Questions about fees, reimbursement, or out-of-network arrangements are welcome. Please contact the practice if anything is unclear or a concern arises.

For information about out-of-network reimbursement and access to the MENTAYA benefits checker, visit: https://www.robromano.com/getting-started/#benefits-checker

**MENTAYA is an independent third-party service. Its results are estimates and do not guarantee coverage or reimbursement. Please confirm your benefits directly with your insurance company. Your insurance company remains the final authority on how your benefits are applied and is best positioned to explain the specific terms, coverage, exclusions, and reimbursement provisions of your policy.**

**Important:** Do not enter a card number, expiration date, security code, bank account number, or other payment credentials on this form. Payment information must be provided separately by phone, in person, or through the designated payment processor.

## Acknowledgments and Signature

☐ I authorize charges as described above.

☐ I understand that this practice is out of network, that I am responsible for all fees, and that I may contact the practice at any time with questions or concerns.

Payment method owner's name (printed)

Date (MM/DD/YYYY)

Payment method owner's signature

**Revocation:** To revoke this authorization, please notify the practice in writing. Revocation is effective when received, applies only to future charges, and does not affect charges already incurred or processed.