Terasa L. Davis, Psy.D., PC

Insurance/Payment Agreement

300 Towncenter Blvd
Suite C
Tuscaloosa, Al 35406
(205) 391-9777
Fax (205) 391-9766

PLEASE PRINT CLEARLY

Credit Card #: _____

Expiration Date: _____ - _____

CVV#: _____ Zip Code: _____

Name on Card: _____

Phone # to contact before running the card: _____

Per our policy, we require a **VALID** credit card on file, in the event that your insurance does not pay their portion of your bill (deductible not met, services not covered, etc.). In order to confirm that your credit card is valid, we require that your first payment be made to **this** credit card.

Disclaimer: We will not run your credit card without first making you aware of the charges. We will gladly accept a payment plan, in the event your insurance does not pay their full portion. We will leave you a voicemail if you do not answer, and give you three days to contact our office before running the card.

_____ _____

Signature Date