Caring Home Care, Inc.

1011 NW 51st Street, Suite 6 • Ft Lauderdale, FL 33309
Phone: 954-318-0747 • Fax: 954-318-0878

❑ Dade Office	❑ Broward Office	❑ Palm Beach Office	❑ Orlando Office
Phone: 954-318-0747	Phone: 954-318-0747	Phone: 561-424-2477	Phone: 407-499-4320
Fax: 786-916-2401	Fax: 954-318-0878	Fax: 561-424-2478	Fax: 407-499-4321
Lic # 30211130	Lic # 30211170	Lic # 30211511	Lic # 30211597

Debit/Credit Card Payment Authorization Form

I _____ authorize Caring Home Care, Inc. to charge my credit card account for service
(Full name)

rates listed below on or after _____ for _____
(Date) (Name of Patient)

C.N.A/ HHA Care Hourly $_____ C.N.A/ HHA Live-In Daily $_____ Mileage Charge _____ (per mile)

Billing Address Phone# _____

City, State, Zip _____

As It A ears On Credit Debit Card

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder Name

Account Number _____

Expiration Date

CVV2 (3 digit number on back of Visa/MC/Discover, 4 digits on front of AMEX) _____

I authorize Caring Home Care, Inc. to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form. This authorization cannot be revoked by cardholder unless two (2) weeks' notice has been given to Caring Home Care, Inc.

POA/Card Holder Signature: _____ Date: _____

_____ **Insurance Patients:** I understand that if the assignment of benefits is accepted, Caring Home Care, Inc. will receive a policy confirmation and therefore Caring will not charge credit/debit card for weekly invoices or security deposit. If for some reason confirmation is delayed, not approved, only pays partial or coverage is exhausted the credit/debit card on file will be charged in the total amount due including security deposit. I understand that security deposit may increase if services increase and, or additional hours weekly are needed.

If Client is responsible for any portion of payment: (Check all that apply)

_____ I authorize Caring Home Care, Inc. to charge the credit/debit card on file for weekly invoices.

_____ I authorize CARING to charge my credit/debit card $_____ (initial_____) in advance as Security Deposit which represents an estimated amount for one week of caregiver services, to be held for application against final invoice or any payment due. I agree that the above Security Deposit may be increased and my Card charged accordingly if the estimated charge for one week of services increases for any reason (such as increase in hours or types of service).

_____ I further authorize/agree that CARING may charge the CARD on file or replacement card for all sums owing at the termination of services for any reason.

_____ I will use a different method of payment (Check, Money Order, and OR Different Credit/Debit Card) and pay in full 7 days after the invoice date. I understand that if no payment is received by Caring Home Care, Inc. the credit/debit card on file will be charged.