FINANCIAL RESPONSIBILITY POLICY

_____ requires that all patients provide a current credit card to be maintained securely on file.

By providing _____ with my credit card information, I hereby authorize _____ and its agents to charge my credit card on an as needed basis for the amount(s) due for service(s) rendered and late cancellation/no show fees.

This document designates that my signature is on file and therefore is not required each time a transaction is processed. This authorization will remain in effect until _____ receives written notification from me of its termination. If my credit card information listed below becomes invalid or changes for any reason, I will notify _____ as soon as possible by email [insert email] or phone [insert phone number] and provide a new valid credit card to be charged for the payment of any outstanding balances owed.

Any overpayments will be credited back to the credit card on file. Having credit card information on file does not compromise the payer's ability to dispute a charge or question a balance owed.

My credit card statement will serve as a receipt for payments that have been processed. I may contact _____ at [insert email] or [insert phone number] regarding any billing questions or to request an itemized receipt.

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CREDIT CARD INFORMATION

Name on Card

Credit Card Number

Expiration Date | Security Code | Postal Code

_____ _____

Client/Patient or Responsible Party Signature
Signature

Date