# Patient Care Payment Agreement

**For Charges billed to insurance**

In those instances in which an insurance company has made partial payment for services, I authorize you to collect outstanding balances ("patient responsibility," including co-pays, co-insurance, deductibles, non-covered services) on my credit card listed below.

**For Charges not billed to insurance**

1. **Any appointment cancellations that I make less than 24 hours prior to the reserved time, I authorize you to collect up to, but not exceeding, the full price of the visit fee on my credit card listed below.**
2. If I should make payment by check that proves to have insufficient funds, I authorize you to collect the non-payment, plus $10 returned check fee, on the credit card listed below.

If the card number provided is invalid or does not accept charges, I understand that I will be charged a $10 rebilling fee.

NAME_______________________________________________________

Credit Card MASTERCARD VISA AMEX

CARD NUMBER____________________________________________________

EXPIRATION DATE____________________________

SIGNATURE__________________________________DATE______

WITNESS____________________________________DATE___________

_____I prefer to have statements mailed to me before charging my credit card so that I have the opportunity to bay by check. However, I understand that if payment is not received within 3 weeks of the statement date, the balance due will be charged to the credit card listed above.