CREDIT CARD AUTHORIZATION

I, ________________________________, am authorizing Laguna Family Health Center, Inc. to charge my credit card in the event that I fail to show for a scheduled appointment or do not notify the office of my inability to attend a scheduled appointment at least 24 business hours in advance. Furthermore, for outstanding payments equal to or greater than 60 days, I authorize Laguna Family Health Center, Inc. to charge my credit card for the full amount due. I understand that I am responsible for any visits in which insurance denies or will not cover. I will not dispute charges for sessions I have received or that I have not cancelled less than 24 business hours in advance.

Card Type (circle one): Visa MasterCard American Express Name on Card:____

Card #:____Expiration Date: ______________Security Code:____________

Billing Address (if different then primary):

____ This form will be securely stored in your clinical file and may be updated upon request at any time. Please note, your credit card will *not* be charged unless the following: no-show for a scheduled appointment, cancellation less than 24 *business* hours in advance, or participation in treatment (ie. appointment or phone session) without payment rendered.

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Patient / Guardian Signature