LAGUNA FAMILY HEALTH CENTER, INC.
CREDIT CARD AUTHORIZATION & POLICY

It is our office policy to collect credit card information from all patients or their responsible parties and to maintain this information on file in a HIPAA compliant and confidential manner. We maintain this information for three purposes:

1) We require that **insurance co-payments/fees be paid on the date of your visit**. If a patient is not able to pay their co-payment or fees at the time of the visit with cash or check, we will have their credit card information on file and will process the payment for them. It is too costly for our practice to regularly bill a patient for their co-payment/fees unless this has been agreed to in advance.
2) If an appointment is **cancelled in less than 24 business hours or a patient no shows for a scheduled appointment**, the full fee is due and will be charged to the card on file. No-shows and late cancels cannot be billed to insurance.
3) If a patient becomes **90+ days overdue, with any balance**, we will process the payment using the credit card information or they may set up a monthly installment plan as agreed on by office administration. This would only occur if multiple attempts to reach the patient and/or set up a payment plan have not been returned.

Laguna Family Health Center, Inc. does not accept patients without a valid credit card on file unless agreed to on a case by case basis.

I,_____,am authorizing Laguna Family Health Center to charge my credit card for the reasons stated above. Furthermore, for outstanding payments equal to or greater than 90 days, I authorize Laguna Family Health Center to charge my credit card for the full amount due. I am aware that my card will be manually entered and thus no signature obtained but I am consenting to this per the above parameters. I will not dispute charges for sessions I have received or that I have not cancelled less than 24 business hours in advance. If I choose to dispute a charge to my credit cardcompany, a copy of this credit card authorization will be provided.

Card Type (circle one): Visa MasterCard American Express

Name on Card:_____Relationship to Patient (circle one): Self Parent Spouse Other

Card #:_____Expiration Date:_____Security Code:_____

Billing Zip Code (if different then primary): _____

_____

Signature of Cardholder (if different then patient) ***Date***

_____

Patient / Guardian Signature ***Date***