CANCELLATION-RESCHEDULING-NO SHOW POLICY

We value your time and thrive to provide quality care. We never overlap appointments (double or triple bookings) with the aim to provide enough time for your in-office encounter. We respectfully ask that if you're unable to attend your scheduled appointment that you call as soon as possible.

Cancellations or rescheduling **within 48 hours** of a scheduled appointment and no shows are subject to a **$100 fee**.

CREDIT CARD AUTHORIZATION FORM

We require that a credit card be kept on file for payment of any co-payment, deductible and/or charges that may not be covered by your health insurance.

Please note the cancellation/ rescheduling/ no show fee will be **charged the day of the scheduled appointment**.

This form will be kept confidential.

PATIENT'S NAME ____

NAME AS IT APPEARS ON CREDIT CARD ____

BILLING ADDRESS IF DIFFERENT FROM HOME ADDRESS PROVIDED

____

EMAIL ADDRESS ____

AMEX/DISCOVER/MC/VISA CARD # ____

EXPIRATION DATE _________________________ VERIFICATION CODE (3 or 4 DIGITS) _______________

I acknowledge and authorize Select Primary Care to charge the above credit card account for any co-payment, co-insurance, deductible and/or charges not covered by my health insurance. I acknowledge that my card will be run in the event payment is not received within 30 days after I receive a statement with the exception of cancellation/rescheduling or no-show fee.

I agree to receive billing statements, invoiced and receipts via the email I have provided to this office.

I agree to update any information regarding this credit card account.

Cardholder Signature: _____________________________________ **Date** ______________________

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