CLINICAL CARE CONSULTANTS

AUTHORIZATION AGREEMENT FOR PAYMENT

This Agreement is for the patient portion of the bill for services rendered. This Agreement authorizes Clinical Care Consultants to charge your debit/credit card for your co-pay, co-insurance, any unmet deductible, no show or cancellation fees, and any outstanding balance on your account.

I, the undersigned, authorize Clinical Care Consultants to keep my signature on file and to charge the debit/credit card identified below for the fee(s) and/or balance not paid by my insurance company.

I assign my insurance benefits to Clinical Care Consultants. I understand that I am financially responsible to Clinical Care Consultants for charges not covered by insurance and this Agreement. I understand that a No Show or Late Cancellation fees will be charged to my debit/credit card on the day that service was to be performed. I understand that this form is valid unless I cancel such Agreement through written notice to Clinical Care Consultants.

Clinical Care Consultants acknowledges that the origination of transactions to your account must comply with the provisions of U.S. law.

Client Name _____

Cardholder's Name _____

Cardholder's Street Address _____ZIP _____

Credit Card # _____

Expiration Date _____ Security Code _____

_____

Cardholder Signature Date