Kameron Health PLLC
15922 Eldorado Parkway, Suite 500 #647
Frisco, TX 75035
Tel: 469-634-6690
Fax: 972-433-5038

Patient Name: _____

Today's Date: _____

Authorization to save credit card in medical file

The undersigned agrees and authorizes the medical practice to save the credit card information indicated below in the medical record as "card on file" and to make the corresponding charges for the services rendered and / or for the separate time for my appointment in case I do not show up without due cancellation according to the rules of practice that have been provided by means of the document signed by me "Patient welcome / rules of practice".

Medical practice: Kameron Health PLLC.

I authorize Kameron Health PLLC medical practice to process the card described above as "Card on file". I understand that this authorization will remain in effect until the account on this credit card expires. The patient can also revoke this form by submitting a written request to the medical practice.

Consent of financial responsibility

Late Cancellation and No-Show to Scheduled Appointment Policy

Thank you for choosing Kameron Health PLLC as your provider for your psychiatric care. I am committed to providing the best possible care. Your full understanding of my financial policy is important to our professional relationship and must be signed prior to our first appointment. Please ask questions if you have any questions about service charges or the financial policy. Your time is valuable and so is mine. I have reserved time for you and I plan around that reserved time out of respect for your time. When you do not show up for your appointment, you are taking away valuable time that could have been used for someone else who needed to be seen. In addition, I am not a salaried doctor; when you schedule an appointment, you are contracting with me and agreeing to pay for my professional time regardless of whether you use it or not. In other words, it is not the Practitioner's responsibility to pay for your missed or shortened appointment, therefore, you are responsible and you will be billed.

CREDIT CARD INFORMATION

By signing this document, you agree to have your credit card information stored by Kameron Health, PLLC until your file has been closed. You also authorize Kameron Health, PLLC to charge your credit card for any outstanding financial responsibilities such as copayments, coinsurance, no show/late cancellation fees and deductible payments. NOTE: Patients will be contacted prior to charging their card. Insurance does not cover any cancellation/no-show fee. If you are unable to keep your appointment for any reason, you must give 4 hours advance notice;

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otherwise, you would be charged $40 which is non-refundable and will not be applied toward your co-payment, deductible, or co-insurance. Please complete the credit card information section below as this information is required prior to any appointment can be scheduled.

Name as it appears on credit card: _____

Card Type (Circle One): Visa MasterCard American Express Other: _____

Card Number: _____

Expiration Date: _____ 3-Digit Code on the back of card: _____

Billing Address Including Zip Code: _____

_____

Patient Full Name_____ Patient Signature_____Date: _____