Payment Policies and Procedures

Methods of Payment (Please select your Preference)

___ Check

___Cash

___ Visa or Mastercard

Insurance co-Payment

$ __________ Per Visit

Cancellation/No Show Policy:

I agree that I will pay $75.00 for missed appointments. Initials ________

Credit Card Authorization Request:

I authorize DeFrancisco and Associates, LLC to charge my credit card for the following purposes:

- Co-Payments
- One time payments on an account
- Any outstanding balances after date of service
- Charges for missed appointments

Name on Credit Card:

____

Type of Card (Circle one) Visa MasterCard

Card # ___________________________________ Expiration Date: ____________________

Security Code (three digit code of back of card) __________________
Zip Code that credit card is billed to: _____________

I hereby give authorization for payment of insurance benefits to be made directly to De-Francisco and Associates, LLC, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event

of default, I agree to pay a 30% collection fee and reasonable attorneys fees. I hereby authorize this healthcare provider to release all necessary information to secure the payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original.

Client or Authorized Person

Signature ____

Date ____