

# PAYMENT POLICY Pacific Coast Psychiatric Associates Inc.

2019 Webster Street, SF CA 94115 \* 415-409-0944 \* Fax 415-447-8665

Effective July 1<sup>st</sup>, 2010

PCPA is trying to reduce the use of unnecessary paper in an effort to be more environmentally friendly. We therefore will no longer be sending a paper invoice on a monthly basis. If you would like a receipt, please request one at time of service and one will be printed for you.

**REQUIRED:** We must have a credit/debit card account to keep on file:  
Please initial:

\_\_\_\_\_ *I understand that payment must be made AT EACH TIME OF SERVICE. If payment is not made at that time, the credit card on file will be charged for the balance.*

\_\_\_\_\_ *I understand that any balance due to a claim denied by my insurance or a deductible will be automatically charged to my credit card.*

\_\_\_\_\_ *I understand that my credit card will be charged for missed appointments and late cancellations of less than 48 business hours notice (\$175 for a medication visit and \$225 for a therapy appointment).*

## **CREDIT CARDHOLDER INFORMATION**

PLEASE CIRCLE ONE



VISA

MASTERCARD

DISCOVER

NAME ON CREDIT CARD

CARDHOLDER'S E-MAIL ADDRESS

## **CREDIT CARD INFORMATION**

ACCOUNT NUMBER

EXPIRATION DATE

SECURITY CODE:

BILLING ADDRESS

CITY

STATE

ZIP CODE

## **AUTHORIZATION OF CARD USE**

I certify that I am the authorized holder and signer of the credit card reference above.  
I certify that all information above is complete and accurate.

I hereby authorize collection of payment for all charges as indicated above. I understand that this authorization will be valid until such time when I inform PCPA in writing of my decision to terminate this authorization.

\_\_\_\_\_  
Cardholder's Name

\_\_\_\_\_  
Cardholder's Signature

\_\_\_\_\_  
Date