ACKNOWLEDGMENT OF FINANCIAL, NO-SHOW, CANCELLATION AND MEDICATION REFILL POLICY

☐ I hereby authorize **ConnectCare & Wellness LLC** to furnish information to insurance carriers concerning my illness and treatment for the purpose of processing my insurance claim. I hereby assign all payments for medical services rendered to myself or my dependents.

☐ I understand that all current and prior patient balances, including coinsurance and deductibles, are due at the time of service, and that I am required to present a valid photo ID and insurance cards at every visit.

☐ I understand that, in order to book any appointment, I will be required to place a credit or debit card on file. This card will be used only if I arrive late or fail to attend a scheduled appointment.

☐ I understand that a **$50.00 fee** will be assessed if I do not show up for my appointment or fail to cancel my appointment at least **24 hours in advance**.

☐ I understand that arriving after my scheduled appointment time may result in the need to reschedule my appointment, and a **$50.00 fee** may be charged.

☐ I understand that my credit or debit card will not be charged for any past-due balances without my authorization.

☐ I understand that I am required to contact my pharmacy directly for prescription refills and must allow **two (2) business days** for refill requests to be processed.

Patient Name:_____ DOB:_____

Guardian Name:_____ Relationship: _____

I acknowledge that I have received a copy of this document and have reviewed it. I agree to comply with these terms and acknowledge that any fees incurred are my responsibility.

Patient/Guardian Signature:_____ Date: _____

FINANCIAL, NO-SHOW, CANCELLATION AND MEDICATION REFILL POLICY

CREDIT CARD AUTHORIZATION FORM

CARD HOLDER INFORMATION–print only

Name on Card: _____

_____Billing Address: _____

_____City: _____

_____State: _____Zip: _____Phone Number: ___

Email Address:_____

CREDITCARDINFORMATION

☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Credit Card Number: _____

Expiration Date (MM/YY):_____/ _____CVV: _____

PAYMENT AUTHORIZATION

I authorize **ConnectCare and Wellness LLC**. to charge the credit card indicated in this authorization form according to the terms outlined below. This payment is for:

No-show or cancellation of appointment in accordance with the Financial, No-show/Cancellation and Prescription Refill Policythat I have received

Amount to be Charged: $50.00

AUTHORIZATION

I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company, so long as the transaction corresponds to the terms indicated in this form.

Signature: _____Date: _____