Meridian
HEALTH
1325 Airmotive Way
Suite 240
Reno, Nevada 89502
(775) 737-9001 phone
(775) 870-1628 fax

Credit Card Authorization Form

PAYMENTS:

______ (Initial) I hereby authorize Meridian Health to charge the balance due for each session. Payment will be processed on the day of service. I understand that if I do not show for my appointment, I will still be charged for that date of service. Last minute cancellations/No Call/No Shows are billed at a rate between $65-$300 depending on insurance plans, cash clients and newly established clients will be billed the entire $300 cash rate.

POLICIES:

______ (Initial) Payment is considered late if we attempt to run your credit card and it is denied. Any balance on your account will be charged to the card on file once funds are available. In addition, a late fee may be charged for any unpaid balances. At times insurance companies may deny

______ (Initial) Payment made for services delivered by Meridian Health are non-refundable.

______ (Initial) Being the authorized cardholder, by initialing and signing this agreement I understand and agree to the terms set forth in this agreement, agree to pay, and specifically authorize to charge my credit card for the services provided. I further agree that in the event my credit card becomes invalid, I will provide a new valid credit card upon request, to be charged for the payment of any outstanding balances owed. I also understand I am waiving my right to dispute any charges with my bank for claims of services not received by cardholder or other similar claim of non-service.

Client Name: ____

Client Billing Address: ____

Type of Card:

☐ Visa ☐ Mastercard ☐ Discover ☐ American Express ☐ HSA/Flexspending

Card Number: ____________________________________ Expiration Date: ______ Security Code: ________

The undersigned guarantees performance of the financial provisions of this agreement.

Cardholder Name: ____

Cardholder Billing Address: ____

Signature of Cardholder: __________________________________ Date: _______________