ROUND ROCK PSYCHIATRY
ISRAEL C. CALZADA, MD

Round Rock Psychiatry
www.roundrockpsychiatry.com
p: 512-550-1715; f: 512-366-5523

Credit Card Charge Authorization

I understand that full payment is required at the time of service by either cash, check, or credit card. Full payment is also required for missed appointments and cancellations with less than 24 hours prior notice (including weekends).

I also understand that the financial responsibility for services provided is mine, and that I must file for any insurance reimbursement to which I may be entitled because Round Rock Psychiatry will not file insurance claims on my behalf.

I understand that the credit card listed below will be charged for services rendered and for the missed and cancelled appointments with less than a 24-hour notice. If the credit card charge is denied, I will be billed separately for the appointments. Round Rock Psychiatry will not schedule any further appointments until I pay all outstanding balances.

I agree to call and notify the clinic, in advance of my next scheduled appointment, if my address, phone number, or responsible party has changed.

I hereby authorize Round Rock Psychiatry to charge my credit card for services rendered to me or the patient whose name appears below (and for appointments missed or cancelled with less than a 24-hour notice) at current posted rates (see Fee Schedule).

Patient Name (printed)_____

Credit Card #:_____ Security Code: _____ Exp. Date: _____
Name (as printed on card):_____
Billing Address (shown on the card statement): _____
City:_____ State: _____ Zip Code: _____

By signing below, I am authorizing Round Rock Psychiatry to charge my credit card for the professional services as described above. I certify that I am the owner of the credit card listed on this form and can authorize charges to this card.

Cardholder' Signature_____Date_____

Cardholder's Relationship to Patient (if other than self)_____