Patient Name ______________________ Date of Birth __________

Credit Card Authorization

I authorize the staff of The Clinic to automatically bill the credit card (below) for charges associated with my treatment or the treatment of the patient named above.

Name on Card ______________________ Billing Address ______________________

Card Number __________ Exp. Date ______ Sec. Code ______ City __________ State ____ Zip ____

I understand that billed services will be subject to the parameters agreed upon between myself and my treating clinician and outlined in the "Policies and Procedures Agreement." I have received a copy of this agreement and understand these policies.

Cardholder Signature ______________________ Date __________

❑ *Check if cardholder is not the patient*

Insurance Submission Authorization

Do you have insurance? ❑ Yes ❑ No Would you like us to bill your insurance? ❑ Yes ❑ No

If you would like us to submit insurance claims on your behalf, please read the following, attach a photo of the front and back of your insurance card, and sign below. Otherwise, you may skip this section.

This document authorizes the staff of The Clinic to automatically submit electronic claims to the patient's insurance company for charges associated with the treatment of the patient named above. The undersigned acknowledges that The Clinic may be an out-of-network provider and in such cases is submitting claims as a courtesy service. The undersigned takes full responsibility for following-up with insurance company regarding payment. Payment will be sent directly to the insured.

I understand that billed services will be subject to the parameters agreed upon between myself and my treating clinician and outlined in the "Policies and Procedures Agreement." I have received a copy of this agreement and understand these policies.

Signature of Insured ______________________ Date __________

Insurance card (front)

Insurance card (back)