SOUTH COUNTY HEALTH

SOUTH COUNTY MEDICAL GROUP

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

☐ I hereby authorize South County Health to furnish information to insurance carriers concerning my illness and treatment process to process my claim. I hereby assign all payment for medical services rendered to myself or my dependents. In the event that the patient is a minor, I attest that I am the parent and/or legal guardian of said patient and agree that I am responsible for all costs related to services rendered to the patient herein.

☐ I understand all current and prior patient balances including coinsurance and deductibles are due at the time of service and that I will present my ID and insurance cards at every visit.

☐ I understand that in order to book any appointments I will be required to put a credit/debit card on file that will be specifically used if I am late or do not attend an appointment.

☐ I understand that a $50.00 charge will be assessed if I do not show up for my appointment or call to cancel my appointment within 24 hours of my appointment.

☐ I understand arriving after my scheduled appointment time may result in having to reschedule my appointment, and a $50 fee will be charged.

☐ I understand my credit/debit card will not be charged for any past due balances without my permission.

☐ I understand I am required to call my pharmacy for refills and must allow 2 business days for those refills to be processed.

Patient Name: _____ DOB: _____

Guardian Name: _____ Relationship: _____

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

Patient/Guardian Signature: _____ Date: _____

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CREDIT CARD AUTHORIZATION FORM

CARDHOLDER INFORMATION – print only

Name on Card: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Email Address: _____

CREDIT CARD INFORMATION

☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Credit Card Number: _____

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

PAYMENT AUTHORIZATION

I authorize South County Health System 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 Policy that 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: _____