## MODIFY

## <u>CREDIT CARD GUARANTY OF PAYMENT</u>

I understand that Modify, P.C. will be billing my insurance carrier for therapy and/or evaluative services. I further understand that I am responsible for all reasonable and customary fees that my insurance carrier does not cover such as deductibles or co-payments. I am aware that Modify, P.C. will bill my insurance carrier as a courtesy to me. I understand that while Modify, P.C. provides the courtesy of verifying my benefits, it is my responsibility to know my benefits and to follow up with any and all insurance disputes. If disputed due to the failure of the insurance carrier or me, the payment in full becomes my responsibility.

I, as the credit card holder, authorize payment to be processed on my credit card for services rendered for the client listed below.

I understand that I have given Modify, P.C. my credit card for the purpose of charging a co-pay and/or coinsurance and deductible.

I understand that Modify, P.C. may charge my credit card the full amount due (minus insurance pending) if I do not make a payment within 30 days of the statement date. Also, I understand that because I have not made payment that Modify, P.C. is not required to contact me prior to the charge and that they are not responsible for any fees that may occur as a result of limited funds.

**<u>Cancelation/ No Show Policy:</u>**

I agree that I will be charged a fee of $100 for missed appointments or appointments canceled with less than a 24-hour notice.

Initials: _____

I have read and understand this form. I authorize Modify, P.C. to charge my card. I attest that the information below is true and accurate.

I understand that if my portion of the balance reaches $250 services may be terminated.

Signature: _____ Date: _____

Account Type:  ☐ Visa  ☐ MasterCard  ☐ AMEX  ☐ Discover

Patient Name: _____

Cardholder Name: _____

Billing Address/Zip Code: _____

Account Number: _____

Expiration Date: _____  CVV: _____

Signature of Cardholder: _____ Date: _____