Psychiatric Alternatives & Wellness Center

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Credit Card Consent Form

Psychiatric Alternatives and Wellness Center keeps credit card information on file in order to make payments for doctor visits easy and convenient. Your credit card information will be kept strictly confidential.

Card Type: ◯ American Express ◯ Discover ◯ MasterCard ◯ Visa

Credit Card Number: _____

Name on Credit Card: _____

Expiration Date: _____ /_____ CVC: _____ Zip Code: _____

I consent to allow Psychiatric Alternatives and Wellness Center ("PAWC") to store my credit or debit card information on file using a PCI-compliant secure payment processor and to charge my card for any costs not covered by the patient's insurance plan for the patient's treatment. I understand that my card will only be charged for fees that have been authorized, including any applicable missed-session or late-cancellation fees.

I understand that my financial responsibility as the card holder does **not** apply to services protected under state or federal mental-health parity laws. PAWC will comply with all applicable state and federal protections for covered services.

I understand that while insurance benefits may be confirmed, confirmation is **not** a guarantee of payment. If the patient's insurance declines to cover any services, I agree that I am financially responsible for all charges for services rendered.

I understand and agree that it is the patient's responsibility (or the parent/legal guardian, if applicable) to know whether the patient's insurance has a deductible, copayment, coinsurance, prior authorization requirement, or any benefit limitations. I agree to allow PAWC to charge my card for any amounts not covered by the patient's insurance.

If the patient's insurance requires a referral from a primary care physician, I understand that it must be obtained by the patient or their parent/guardian. Without a referral, insurance may not pay for services, and I agree that my card may be charged for any resulting balances.

I agree to notify PAWC of any changes to the card information I have provided or any changes to the patient's insurance coverage. If the patient's insurance has changed, is inaccurate, or is terminated at the time of service, I understand and agree that I am financially responsible for the balance in full.

I understand and agree that PAWC may place an administrative hold on the patient's account if a balance exceeds $200 or if a payment is declined twice. During an administrative hold, non-urgent appointments may be paused until the balance is resolved or a new card is provided. This hold does **not** apply to clinically necessary or urgent services, and all clinical decisions regarding continuity of care will be made by a clinician. PAWC will provide notice prior to placing an administrative hold.

Missed and Late Cancel Office Policy

PAWC requires **two full business days (48 business hours)** notice to cancel or reschedule an appointment. Saturdays, Sundays, and legal holidays are not counted as business days.

If adequate notice is not provided, the following fees will be charged to my card on file:

- **$150** for missed or late-cancelled appointments with a psychiatrist
- **$100** for missed or late-cancelled appointments with a psychologist or master's-level therapist

If the patient is not present at the start time of a scheduled appointment, the visit may be marked as missed. Missed-session fees, late-cancellation fees, and sessions where insufficient time remains to provide billable clinical care **cannot** be billed to insurance and are charged directly to the card on file.

I understand and agree that any unpaid balance will be sent to an external collections agency 60 days after written notice has been provided. Once an account has been sent to collections, the patient will be unable to schedule future sessions with any practitioner at PAWC.

A holder of this medical debt contract is prohibited by Section 1785.27 of the California Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. If a person knowingly violates that section by furnishing such information, the debt shall be void and unenforceable.

Patient Name: _____ Patient's DOB: _____

Card Holder's Name: _____ Phone Number: _____

Card Holder's Signature: _____ Date: _____