The Fort Christian Psychiatric Center
Shaw Wendi Fortuchang, M.D., P.C.

CREDIT / DEBIT CARD PAYMENT FOR PROFESSIONAL SERVICES

____ VISA ____ MasterCard ____ AMEX ____Discover

Name as it appears on card _____

Visa/MasterCard/Discover card number _____ - _____ - _____ - _____

American Express card number _____ - _____ - _____

Billing Zip Code _____ Exp. Date _____/_____ CVV2number: _____

I/we authorize The Fort Christian Psychiatric Center/Shaw Wendi Fortuchang, M.D., P.C., to bill the above credit / debit card for professional services as outlined in the Policies. I understand the billing statement will be recorded as either "The Fort Christian Psychiatric Center," or as "Shaw Wendi Fortuchang, M.D., P.C." I will notify Dr. Fortuchang in writing if I no longer want my credit / debit card billed.

_____ _____
Signature of cardholder Date

Credit Card Payment for Late Cancellation or No-Show & Telephone Sessions

I authorize The Fort Christian Psychiatric Center (TFCPC) to charge the above credit card when the patient does not give advance notice for a late-cancellation or no-show, as per the Policies. I also authorize TFCPC to charge the above credit card for telephone sessions. I understand that if I do not want my credit card billed for this purpose, I am still responsible for these fees and will be billed accordingly.

_____ _____
Signature of cardholder Date

GUARANTOR INFORMATION:*(complete only if someone other than the patient is paying for the services)*
Name of party responsible for bill: _____
Address: _____
Home Phone: _____
Business Phone: _____
Date of Birth: _______________

Guarantor-Financial Responsibility Agreement: I, the undersigned, agree that regardless of any insurance coverage, I am financially responsible for all charges generated for this patient. Office policy requires payment at the time of service. I understand that unpaid balances over 30 days past due may carry a late fee equivalent to 1.5% per month of that outstanding balance. I understand that no further services will be rendered until the outstanding balance is paid in full. I understand that unpaid balances over 90 days past due will be referred to a collection agency.

_____ _____
Signature of cardholder Date