THE FORT CHRISTIAN PSYCHIATRIC CENTER / SHAW WENDI FORTUCHANG, MD, PC

OFFICE OF

SHAW WENDI FORTUCHANG, M.D., FAPA

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 _____/_____ CVV / CVC number: _____

Driver's License Number _____ State _____

I 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 understand that a $2 fee will be applied each time this form is used for a manual transaction.**

_____ _____

Signature of cardholder Date

Credit Card Payment for Late Cancellation or No-Show Appointments & 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 cancellation or no-shows for the appointment, as per the Policies. I also authorize TFCPC to charge the above credit card for telephone sessions.

_____ _____

Signature of cardholder Date

Guarantor Information: Name of party responsible for bill: _____

Address: _____

Home Phone: _____ Cell / 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