

Mountain View Psychology, LLC

Payment Authorization Sheet

I agree to pay for all services rendered by Mountain View Psychology, LLC (MVP) that are not covered or are denied by my insurance carrier because: I do not carry medical insurance, MVP does not participate with my insurance carrier or simply because this is the credit card I wish to have any and all copayments/coinsurance amounts due to MVP, applied toward. I agree that payment for all services rendered will be charged to this credit card. If the patient no shows for a scheduled session, MVP has the right to charge this credit card \$75 per MVP's cancellation policy as detailed in MVP's intake paperwork.

CREDIT CARD/DEBIT CARD GUARANTEE

Check one: VISA MASTERCARD DISCOVER

Please Print

Name on Credit Card: _____

Billing Address for this Credit Card: _____

City: _____ State: _____ Zip Code: _____

Credit Card #: _____

Expiration Date: _____ 3-digit Security Code: _____

If your credit card/debit card is denied for applicable charges or you fail to pay according to the agreed upon payment plan, your account will be referred to collections/an attorney. All collection and attorney fees, expenses, and court costs will be charged to the payee responsible for the account.

I have read and understand the above conditions and financial policy:

Card Holder Signature: _____ Date: _____

Patient's Name: _____ DOB: _____

312 Neff Avenue ~ Harrisonburg, VA 22801
Phone: 540.433.2858 ~ Fax: 540.433.1175