KRYSTAL
HERNANDEZ-KANE

PSYCHOLOGIST,LLC

Krystal Hernandez-Kane, Ph.D.
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Financial Agreement and Authorization to Charge Credit Card

Co-payments are due at the time of service.

Insurance policies are contracts between you and your insurance company. I file these claims as a courtesy, but it is your responsibility to resolve any difficulties with insurance that are beyond my control. If insurance is not paying within a reasonable time, you will be responsible for full payment.

If I am not covered by your insurance company, full payment is due when services are provided.

Any appointments scheduled but not kept, as well as any appointments cancelled within 24 hours of scheduled time will be charged fees as described in *Professional Services and Informed Consent*. This is a charge not covered by your insurance company.

Client Name: _____ DOB: _____

Name on Credit Card: _____

Zip Code of Credit Card Billing Address: _____

Phone Number of Cardholder: _____

Credit Card Number: _____

Expiration Date: _____ Security Code/CVV: _____

I authorize Krystal Hernandez-Kane, Ph.D. to charge my card for office charges and I agree to update this information if it changes.

I understand that, if my credit card does not accept the charge, I will immediately make the payment to the practice.

I understand that I may cancel this authorization at any time, but by doing so, I acknowledge that the balance owed will be due & paid in full.

I acknowledge that credit card transactions could be linked to Protected Health Information, but if I dispute a charge, I agree that the practice may provide information to the credit card company to support the charge.

_____ _____

Signature of Card Holder Date