

609 Bryden Ave Suite B Lewiston, ID 83501 (208)816-8746

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, am the holder of

Visa\_\_\_\_, MasterCard\_\_\_\_\_, Discover\_\_\_\_\_ (check one please)

Cardholder name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Card number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration date:\_\_\_\_\_\_\_/\_\_\_\_\_ CVV# (on back of card):\_\_\_\_\_\_\_\_\_Card Zip Code\_\_\_\_\_\_\_

I authorize Mountain View Health PLLC to charge my credit card. **Initial\_\_\_\_\_\_**

I understand and agree that the Mountain View Health PLLC will charge my credit card $100.00 fee if I do not cancel any appointment within 1 business day, if I am late for my scheduled session or if I do not show for my scheduled session. **Initial\_\_\_\_\_\_**

I understand and agree that the Mountain View Health PLLC will charge my credit card for any outstanding balance past 30 days from date on my invoice. **Initial\_\_\_\_\_\_**

I understand that if the above card information is incorrect or is denied I will be charged a $50 fee due immediately. **Initial \_\_\_\_\_\_**

I understand my insurance will not pay for late cancels, missed appointments or fees and I will be responsible for payment. **Initial \_\_\_\_\_\_\_**

I understand that if I refuse to leave a valid card on file I must pay all balances within 30 days or I will be discharged from Mountain View Health PLLC and I will no longer receive treatment including: medication management and/or psychotherapy. I also understand that all no show fees are due the same day or I can not schedule a new appointment and any current appointments will be cancelled until the fee is paid. **Initial\_\_\_\_\_\_\_\_**

I hereby authorize Mountain View Health PLLC to process my credit card with their merchant services. I understand that the Mountain View Health PLLC is not responsible for any security or liability issues with merchant services.. **Initial\_\_\_\_\_\_**

I have read this entire agreement and understand that I will be held fully responsible for its terms and charges and I agree that all charges are final and that there are no refunds for services rendered.

Patient Name (Print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Parent/Legal Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

Effective Date of this notice: April 6, 2020 | Mountain View Health PLLC