Payment Guarantee – Credit Card

As a courtesy, we'll bill your insurer for our services. But if for any reason it does not pay in full, or it does not timely do so, you are responsible for full payment. If your insurer has not paid us within 60-days of submission of your bill, we'll let you know, so that you may contact your insurer directly.

This means that even if we bill your insurance, you are responsible for any fees that it does not pay, including any deductible, co-pay, co-insurance, and credit card or bank fees. Also, some of our fees, such as the cancellation fee, will not be billed to your insurer and will be your sole responsibility to pay.

Accordingly, please compete the following credit card authorization to cover any above described fees.

Name on Card: _____ Phone: _____ Email: _____

Type of Card: ☐ Visa ☐ Mastercard ☐ AMEX ☐ Discover ☐ Other: _____

Card Number: _____ Exp. Date: _____ CVC: _____

Card Billing Address (Street/City/State/Zip): _____

_____

Authorization

I, _____, hereby authorize Landstrom Neuropsychological Center, P.C. to charge my credit card as described above. I further affirm that I am authorized to use this credit card and will not dispute any charge for services rendered.

Signature Authorizing Charge(s): _____ Date: _____

**This authorization is valid for 3-years, unless first revoked in writing. Such revocation is only effective for prospective services.