Doorways, LLC

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Payment Policy

It is the policy of Doorways, LLC to obtain and maintain on record a valid credit/debit card and authorized signature. This will remain in a secure and confidential file as a guarantee of payment and allows us to avoid having to take collections action against any patient and/or guardian. **This credit/debit card will be used to pay for services including missed or late cancellations**. **You will be charged $50 for a missed or late cancellation of an appointment.**

If you elect to use your insurance benefits to pay for services then you will need to complete this form, as having benefits is **not** a guarantee of payment. If we have a contract with your managed care insurance company, the billing procedures of that company will be followed. Our staff will attempt to collect from your insurance company. However, in the event that any insurance company obligated by contractual agreement to make payments on your behalf for services provided, refuses to make such payment, you will become personally responsible for that amount and your credit card will be charged.

By signing this credit card agreement, you hereby authorize us to collect any outstanding amount on the credit card listed below. In the event that the credit card does not result in the reconciliation of your account then Doorways, LLC reserves the right to send the account to an attorney or collection agency. **Please be advised if outstanding invoices are turned over to Collections (after 90 days) there will be a 30% fee assessed to the outstanding balance.**

This signed credit card collections policy is for use only for services rendered at the offices of **Doorways, LLC**.

Patient's Name: _____DOB: _____

☐ **VISA** ☐ **MasterCard** ☐ **Discover** Is this an HSA (Health Savings Account): **Y☐ N☐**

Card Member Name: _____

Card Number: _____-_____-_____-_____

Expiration Date: _____/_____ CCV Code: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ - _____

Cardmember Signature: _____ Date: _____

Patient Signature (If 18+): _____ Date: _____