Julie Lang, LMFT
405 West Main Street, Grass Valley, CA 95945 (530) 272-5521

Payment Policies
&
Credit Card Authorization Form

Patient Name: ____________________________ Date: _____________________

_______ **(Initial)** I authorize Julie Lang, MFT to furnish information to insurance carriers concerning my treatments and assign Julie Lang, MFT all payments for medical services rendered to myself and dependents. **As a courtesy, benefits are verified but are NOT A GUARANTEE of payment/coverage.** All claims are subject to review by my insurance company.

_______ **(Initial)** Payment Policy: Copays, coinsurance, deductibles, and non-covered services are patient responsibility and will be collected at each visit. You may choose from the options below:

☐ I will pay my balance with cash at the start of each visit.

☐ I will pay my balance with a check made payable to Julie Lang at the start of each visit.

☐ I will pay by credit card- Please keep my card on file and charge my card for all fees associated with my account. I authorize Julie Lang and all associates to charge this credit card and keep the card on file for future payments.

Name on Card ____

Credit Card Number _______________________________ Security Code ______________ CC Type ______________

Expiration Date ________________________ Billing Zip Code ___________________

If you have an unpaid balance, you will be sent a statement via the method(s) below. Please include the best cell phone number and/or email:

☐ Text _____________________________ ☐ Email ______________________________________

_______ **(Initial)** I understand there is a 24-hour cancellation policy. If I do not notify your office 24 hours in advance of missing a scheduled appointment, I will be charged a $75 missed appointment fee and my insurance does not cover this fee.

_______ **(Initial)** I understand that I am solely responsible for the balance due on my account. I agree to pay the unpaid balance due. If your account matures to over 120 days and remains unpaid, you will be sent to collections, and we will no longer be able to assist you with the account. Any accounts in default and sent to collections, could be assessed attorney fees, court costs and interest or a flat fee. We hope this course of action is unnecessary; however, we are required to notify you of this information.

I have read and fully understand the above policies and procedures of Julie Lang, MFT and agree to these terms.

Signature of Patient / Responsible Party: _________________________ Date: _________________