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CREDIT CARD GUARANTEE OF PAYMENT

I understand that I ultimately bear full responsibility for all reasonable and customary fees for rendered services.

Even if insurance benefits and coverage were verified prior to the appointment and are being relied upon to cover 100% of the costs, I understand that it does not absolve me from my financial obligations in the event of insurance denial of payment for any reason. This includes, but is not limited to: underpayment of deductible or copay fees, non-covered service, procedure code or diagnosis, administrative error, lack of preauthorization or expiration of insurance coverage.

With this form, I am granting authorization to charge my credit card for any outstanding invoices that have not been paid within 45 days of the date of service, whether they are private-pay or insurance claims. If reimbursement has not been received within 30 days of the service date, I will be notified of the outstanding balance and encouraged to send payment and/or resolve the situation with the insurance company directly. If the situation remains unresolved and payment has still not been received within two weeks of notification, my credit card will be billed for the full outstanding balance (+ 3.5% merchant fee).

With this form, I am also granting Dr. Juni permission to charge my credit card at the rate of $125 per scheduled hour (+ 3.5% merchant fee) for any missed or cancelled appointments with less than 48-hours advance notice.

I understand that this form is valid for three years from the undersigned date, unless notification of revocation is received in writing.

Client's Name:	
Cardholder name (if different than client):	
Billing Address:	
Type of Credit Card:	☐ Visa ☐ Mastercard ☐ Discover ☐ American Express
Credit Card Number	
Expiration Date	
CV#	

Cardholder Signature: _____ Date: _____