

Francis Holistic Medical Center, P.C.

360 West Boylston Street, Suite 107, West Boylston, MA 01583

Phone: 508-854-1380 Fax: 508-854-0446

I authorize the Francis Holistic Medical Center, P.C. to keep my signature on file and to charge my Credit Card, Debit Card, or Health Savings Account as indicated below for medical services provided by this practice that were not covered by my Health Insurance Plan and/or were subject to a deductible.

I understand this process is needed to circumvent the problems insurance companies present with large deductible on policies. I understand this practice is now standard operating procedure and new patients are accepted only with this completed authorization.

We also would like to make patients aware again of our "no-show" and late cancellation policy. There is a 1/2-fee charge for late cancellations of doctor visits with less-than-48 hours business days notice. There is a \$40 charge for cancellations of IV appointments with less-than-24 hours business day notice and an additional \$25 fee if the IV has been mixed due to late notification. There is a \$50 fee for cancellations of half-day allergy testing and a \$100 fee for cancellations of full-day allergy testing with less-than-24 hours business day notice. The above charges will also be applied to any patients who fail to appear for their scheduled appointments.

Please note again that our office is usually open on Mondays through Thursdays from 8:30 AM until 5:00 PM. Patients with Monday appointments with the doctor will need to call our office on the Wednesday before the office closes to avoid being charged a late cancellation fee.

New patients looking to schedule a consultation or evaluation with a doctor will be required to mail in a \$40 check to hold their appointment as well as to provide us with a valid credit card. Due to the fact that our doctor blocks off a large amount of time for a new patient evaluation and consultation, the Francis Holistic Medical Center, P.C. will deposit any checks mailed in, as well as placing a charge for a 1/2-fee for any new patients that fail to appear for their scheduled evaluations.

Your credit card number will be kept safe by the Francis Holistic Medical Center, P.C. at all times under lock and key. For patients with large deductibles or overdue balances, your credit card will be charged only after three attempts to collect the money due from you. I understand that this form is valid for one year from the date I sign this agreement.

Dated: _____

Patients Name: _____

Please circle one: (Mastercard) (Visa) (Discover) (Health Savings Acct)

Card Number: _____

Expiration Date: _____ V-Code: _____

Cardholders Name: _____

Cardholders Billing Address: _____

Signature of Account Holder: _____