WELL BEING SYSTEMS, PLLC
8687 East Via De Ventura, Suite 318
Scottsdale, AZ 85258
Tel: 480-905-8755; Fax: 480-905-8851

Credit Card Authorization

Our office will always hold appointments times for you in the schedule, and in return requests that you fill out this form. This form authorizes our office to bill your credit card for services and missed sessions. It is kept confidential and private. As a reminder, your insurance company will not reimburse you for missed sessions or late cancellations. Appointments must be canceled within 24 business hours to avoid a fee.

I, the undersigned individual, authorize Well Being Systems, PLLC. to charge my credit card in the event that I (or the party for whom I am financially responsible) fail to show for a scheduled appointment, or do not notify our office at least 24 business hours in advance for a canceled appointment. Furthermore, for outstanding payments of services rendered, I authorize our office to charge my credit card for the full amount due. I agree to not dispute charges for any of these reasons. I further authorize our office to disclose information about my attendance and/or cancellation to my credit card company if I dispute a charge.

Missed sessions or late cancellations are charged $250 for 45 minute scheduled appointments, $100 for 15 minute scheduled appointments, and $350 for initial evaluation.

Card Type (please check one): ☐ Visa ☐ MasterCard ☐ Amex ☐ Discover

Card #: _ _ _ _ - _ _ _ _ - _ _ _ _ - _ _ _ _

Expiration: / Security code*:

* This is a 3-digit code located on the back of your card.

Name (as printed on card):

Name of patient if credit card holder is not the patient:_____

Billing Address: _____Zip:_____
(Street; City, State & Zip)

Signature: _____ _____
(Patient or financially responsible party) Date

*Please note, your credit card will not be charged unless one of the following conditions apply: (a) no-show for a scheduled appointment, (b) cancellation less than 24 business hours in advance, or (c) non-payment of prior bill