1205 S. Whitechapel Blvd.,
#215
Southlake, TX 76092

O: 817-454-0019
F: 817-288-0748

TELEMEDICINE PAYMENT AUTHORIZATION

Name: ____ Date: ____ / ____ / _______

I, ____________________ hereby authorize you to charge my credit/debit card for up to 18 months of service, charged per visit, 2 business days prior to appointment time as the contract for my Suboxone Recovery Treatment, as attached and executed simultaneously, today.
I agree that I am responsible to prepay these charges with credit card before each visit, otherwise I will not be seen.

**NOTE: Prepayment secures your purchase of the doctor's time for the visit time slot you originally reserved, after which time the fee is NOT refundable. This verifies your intent to attend so that the doctor's time is not wasted if you should fail to show for any reason, since we cannot reasonably fill an appointment slot with another patient. Cancellations or failure to pay prior to 2 business days result in NO charge, but your appointment slot is cancelled and given to other patients, requiring you to reschedule.

I acknowledge I am responsible to anticipate and make timely payment of these fees in order to avoid creating an interruption in my treatment.

Should my credit/debit card account become closed, I agree to immediately provide an alternative payment method to The Private Practice.

Contract fees: Telemedicine Minor Care visits - $125.00

Amount Owed today: $__________ Payment Made Today: $__________

Please provide your credit/debit card information below

Card Type: AMEX/ MasterCard/ Visa/ Discover Zip Code for Credit Care: ____________

Credit Card No: ________________________________ Expiration Date: ____ / ____

Security Code: ________ Zip Code of credit card Billing Address: __________________

Patient/Guarantor/ Cardholder Signature: ______________________________________

Date: ____ / ____ / _______