Nashville Child and Family Wellness Center

85 White bridge road, suite 302 • Nashville, tn 37205

phone: 615-238-9100 • fax: 615-393-6940

www·nashville familywellness·com

PATIENT PAYMENT AGREEMENT

Patient Information:

Last Name: _____First_____ MI: _____

Provider Name: _____

Payment Agreement

Payment is expected at the time of service. Payment may be made by cash, check or credit card (Visa, Master Card, American Express, or Discover). Any balances will be due upon receipt of the monthly statement. Accounts over 30 days are subject to a late fee.

To save an appointment time, credit card information will be required. In the event you do not come to your appointment and do not give at least 24 hours notice, the full appointment fee will be charged to your credit card. If you cannot come to your appointment, please call to cancel or reschedule as soon as possible. At the time of your appointment, you may choose another payment method if you do not wish your credit card to be charged.

Guarantor Information (complete only if the patient is NOT paying for the bill):

Name of party responsible for bill: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Phone: _____

Date of Birth: _______________

Social Security Number: _____

Guarantor-Financial Responsibility Agreement:

I, the undersigned, regardless of any insurance coverage, am financially responsible for all charges generated for this patient. Office policy requires payment at the time of service. I understand that unpaid balances over 30 days may be subject to a late fee. I understand that unpaid balances over 90 days past due may be referred to a collection agency.

Signature: _____ Date:_____

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Credit/Debit Card Payment for Professional Services

_____ Visa _____ Master Card _____ Discover _____ American Express

Name as it appears on Card: _____ Billing Zip Code _____

Credit/Debit Card #: _____ Exp. Date _____

Card Security Code # _____
(Located on back of credit card; VISA/Master/Discover 3 digits, American Express 4 digits)

I/we authorize _____ (provider name) to bill the above credit/debit card for professional services at the time of service provided for_____ (patient name). I will notify _____ (provider name) in writing if I no longer want my credit/debit card billed.

Signature of Cardholder: _____ Date:_____

Credit/Debit Card Payment for missed or cancelled appointments:

I authorize _____ (provider name) to charge the above credit/debit card when _____ (patient name) does not give advance notice for a late-cancellation or no-show, as per the policies. I understand that if I do not want my credit card billed for this purpose, I am still responsible for these fees and will be billed accordingly.

Signature of Cardholder: _____ Date: _____

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