Senior Care
MEDICAL ASSOCIATES, INC.

No Show/Late Cancellation
Credit Card Authorization Form

Patient Name: _____ **Date of Birth:** _____

The purpose of this form is to authorize Senior Care Medical Associates, Inc. to retain a valid credit card number on file for you as our patient. This form will be kept confidential and only authorized staff will have access to the information.

If you, as the patient, miss a scheduled appointment without 24 hour notice to cancel or reschedule a Tuesday through Friday appointment or 72 hour notice to cancel a Monday appointment, Senior Care Medical Associates, Inc. reserves the right to charge the credit card listed below $50 for our standard no show fee and a receipt will be sent to the current address on file. This notice serves as your consent to being charged for any and all no shows.

As a courtesy, you will be reminded of your appointment day and time via an automated call or email. It is the patient's responsibility to ensure we have the correct phone number and email address on file. Should you need to cancel or reschedule that appointment, please so do by calling our main line during normal business hours.

Should you refuse to provide your credit card information and sign this form then please understand that you will receive an invoice via mail and no further appointments will be scheduled until payment is received.

Acknowledged, Agreed, & Accepted:

Having read this form and talked with the Physician and/or Staff, my signature below acknowledges that I voluntarily give my authorization and consent to providing the requested information for my credit card to be charged accordingly for the conditions above.

X _____ X _____

Patient Signature Date Staff or Physician Signature Date

(or authorized person to sign for patient)

Name, As it appears on Credit Card: _____

Billing Address: _____

_____

Visa/MC/Disc Card #_____

Expiration Date: _____/_____ Verification Code: _____