KRAMER
PSYCHIATRIC SERVICES, LLC

Credit Card Consent Policy

I, the undersigned, authorize Kramer Psychiatric Services, LLC to keep my signature on file and to charge my credit/debit card account as indicated below. A charge to the credit/debit card will be made under the following circumstances:

1. Missed appointments*
2. Cancellations made less than 48 hours before the scheduled appointment*
3. Payments/copayments made with credit/debit card at the time service is rendered
4. Checks that fail to clear, for any reason**

*Missed Appointment/Late Cancellation Fee: Appointments must be cancelled **at least forty-eight (48) hours** in advance of your scheduled appointment or you will be charged the ***full amount*** for the scheduled service. We can be notified of your intent to cancel an appointment by office voicemail (504-800-6750), email (appointment@kramerpsychiatric.com), or through the patient portal. Reminder calls and/or emails to our patients are not guaranteed and are offered as a courtesy only.

**Checks failing to clear: You will be charged for the amount of the check plus a $35 service charge.

I, the undersigned, understand that this form will be valid for the duration of treatment with this office unless I cancel through written notice to Kramer Psychiatric Services, 3925 N. I-10 Service Rd. W., Suite 201E, Metairie, LA 70002. I also understand that a service charge of 3% will be assessed for each credit/debit card payment.

Patient Name _____ Cardholder Name (if different from patient) _____

Card Type: Visa ☐ Mastercard ☐ Discover ☐ AmEx ☐

Credit Card Number:	
Name as it appears on card:	
Security Code (3 digit # on back of card):	
Expiration Date:	

Cardholder Signature _____ Date _____