STACI R. JOHNSON, M.D.
"OUR SEASONS"

15338 Central Ave. Suite # 103
Chino, CA 91710 (909)742-9724

Credit Card Authorization

It is policy with Staci R. Johnson, M.D. that this Credit Card Authorization be completed in order to schedule your first appointment. This credit card will be used for payment of all services.

This authorization form shall serve as a legally binding contract that provides you with important information regarding the financial practices with Staci R. Johnson, M.D. By signing below you acknowledge that you are financially responsible for the fees for rendered services according to this contract, and that you have read and understand the above information and agree to comply with the above policies. Any question or concerns regarding the contents of this agreement should be discussed with us prior to signing.

You hereby authorize Staci R. Johnson, M.D. to charge your credit card in the event that you fail to show for an appointment or fail to provide advance notice as indicated above and agreed to in this form. Furthermore, for outstanding payments of services rendered, you authorize Staci R. Johnson, M.D. to charge your credit card for the full amount due. You will not dispute charges for sessions which have been rendered nor which have been canceled outside of the cancellation policies listed above. You further authorize Staci R. Johnson, M.D. to disclose information about your attendance/cancellation to your credit card company if a dispute occurs. This form will be stored in your clinical file and may be updated at any time.

IMPORTANT: please not that all Staci R. Johnson, M.D. invoices are sent via email to the email address of the credit card holder. We do not use regular mail unless specifically requested. These contain sensitive information which include diagnostic and appointment codes.

Initial here to indicate understanding
and acceptance of this page: _____ Date:_____

STACI R. JOHNSON, M.D.
"OUR SEASONS"
15338 Central Ave. Suite # 103
Chino, CA 91710
(909)742-9724

CREDIT CARD AUTHORIZATION CONT.

GENERAL INFORMATION:

NAME OF PATIENT:_____

NAME OF FINANCIALLY RESPONSIBLE PARTY:_____

RELATIONSHIP TO PATIENT:_____

CREDIT CARD INFORMATION:

CREDIT CARD TYPE: ☐VISA ☐MASTERCARD ☐DISCOVER ☐AMERICAN EXPRESS

NAME AS IT APPEARS ON CARD:_____

CREDIT CARD NUMBER:_____

CONFIRM:

EXPIRATION DATE(MM/YYYY):_____

SECURITY CODE(3-DIGIT CODE ON BACK OF CARD):_____

BILLING ADDRESS:

STREET:_____

CITY, STATE, ZIP:_____

PHONE NUMBER OF CARDHOLDER:_____

EMAIL OF CARDHOLDER:_____

INITIAL HERE:_____ SIGN HERE:_____

INITIAL HERE TO INDICATE UNDERSTANDING AND ACCEPTANCE OF THIS PAGE: _____ DATE:_____