Weekend Behavioral Health

Dawei Wang, D.O.

19712 MacArthur Blvd Ste: 110, Irvine, CA 92612

Phone: (909) 317-8650 Fax: (866) 358-0456

E-mail: weekendbehavioralhealth@gmail.com

Website: https://www.weekendbehavioralhealth.com/

Credit Card Authorization Form

I, the undersigned, authorize Dr. Dawei Wang or Weekend Behavioral Health to charge my credit card for all appointments in which I do not provide an alternative payment or in the event that I (or the party for whom I am financially responsible) fail to attend a scheduled appointment, or do not notify my provider at least 48 business hours advance notice for a cancelled appointment, as agreed to in the 'Consent for Evaluation & Treatment / Practice Policies' document. Furthermore, for outstanding payments of services rendered, I authorize charges to my credit card for the full amount due. I agree not to dispute charges for any of these reasons and understand that clinical information may need to be released if a dispute is initiated. I further authorize my provider Dr. Dawei Wang or Weekend Behavioral Health to disclose information about my attendance and/or cancellation to my credit card company if I dispute a charge. This form will be securely stored in a clinical file and may be updated upon request at any time.

***Your credit card will be charged if any of the following conditions apply:**

- Participation in treatment (including phone or telemedicine sessions) without payment rendered
- Other services provided such as writing letters/reports, legal proceedings, collateral care, etc.
- Extensive phone calls that require clinical decisions & support lasting more than a few minutes
- Cancellation less than 48 business hours in advance
- No-show for a scheduled appointment

PRIMARY CREDIT CARD INFORMATION:

Type: Visa ___, MasterCard ___, AMEX ___, Discover ___,

Credit Card Number: _____
Expiration Date: _____ Verification/Security Code: _____
Full Name (as printed on card): _____

Client or responsible party (if application) Initial: _____

Billing Address: _____
Signature of patient or financially responsible party: _____
Date:_____

SECONDARY CREDIT CARD INFORMATION (may be HSA):

Type: Visa ___, MasterCard ___, AMEX ___, Discover ___,

Credit Card Number: _____
Expiration Date: _____ Verification/Security Code: _____
Full Name (as printed on card): _____
Billing Address: _____
Signature of patient or financially responsible party: _____
Date:_____