I acknowledge that I have reviewed and understand WFPC's Financial Policy

(Refusal to sign this form does not negate your financial responsibilities outlined in this policy)

_____ _____

Printed Name Date of Birth

_____ _____

Signature Date

Dependents who are 17 years old and under and are patients of West Front Primary Care:

Name _____Date of birth _____ Name _____ Date of birth _____

Name _____Date of birth _____ Name _____ Date of birth _____

Name _____Date of birth _____ Name _____ Date of birth _____

*You can view our Financial Policy on our website at: http://westfrontprimarycare.com/
Click on the tab on the left hand side titled "Patient Communications".

Credit Card on File Authorization

Visa [ ] MasterCard [ ] Discover [ ] American Express [ ]

I hereby authorize West Front Primary Care, PLLC to charge/refund the credit card provided for payment of charges/refunds to my account. I understand that it is my responsibility to have enough credit availability to cover any charges that I may incur. In the case the charge exceeds $200 we will give you a courtesy call prior to charging your credit card. West Front Primary Care cannot be held liable for any "over limit" fees you may incur. This authorization will be kept on file and I agree to update any information on this account. This form will remain in effect until the expiration of the credit card account. Applicants may revoke this authorization by submitting a written request to West Front Primary Care. A new form must be submitted if information such as the list of authorized users and/or the credit card account's number or expiration date is amended.

Accepted ☐ Declined ☐

***Card Holder's Signature: _____ Date: _____**

***Email (required for receipts)**:_____