Yujuan Choy, M.D.
4199 Campus Drive, Ste 550, Irvine, CA 92612
Tel: 949.288.3098; Fax: 949.272.0072

Credit Card Authorization

Dr. Choy will always hold appointment times for you, and in return requests that you fill out this form. This form authorizes Dr. Choy to bill your credit card for services and missed sessions. It is kept confidential and private. As a reminder, your insurance company will not reimburse you for missed sessions or late cancellations. Appointment must be cancelled within 48 business hours to avoid a fee.

I, the undersigned individual, authorize Yujuan Choy, M.D. to charge my credit card in the event that I (or the party for whom I am financially responsible) fail to show for a scheduled appointment, or do not notify Dr. Choy at least 48 business hours in advance for a cancelled appointment. Furthermore, for outstanding payments of services rendered, I authorize Dr. Choy to charge my credit card for the full amount due. I agree to not dispute charges for any of these reasons. I further authorize Dr. Choy to disclose information about my attendance and/or cancellation to my credit card company if needed.

Missed sessions or late cancellations are charged $300 for 50 minute scheduled appointments and $150 for 25 minute scheduled appointments.

Please provide credit card information and not debit cards

Card Type (please check one): ☐ Visa ☐ MasterCard

Card #: __ __ __ __ - __ __ __ __ -__ __ __ __ -__ __ __ __

Expiration date: __ __ /__ __ Security code: __ __ __ (3-digit code located on the back of card)

Name (as printed on card): _____

Name of patient if credit card holder is not the patient: _____

Billing Address: _____ Zip: _____
(Street; City, State & Zip)

Signature: _____ Date: _____
(Patient or financially responsible party)

**Please note, your credit card will not be charged unless one of the following conditions apply:(a) no-show for a scheduled appointment, (b) cancellation less than 48 business hours in advance, or (c) participation in treatment without payment rendered.*

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PLEASE SIGN AND DATE BELOW IF YOU WOULD LIKE DR. CHOY TO BILL YOUR CREDIT CARD FOR REGULARLY SCHEDULED APPOINTMENTS.

Card Type (please check one): ☐ Visa ☐ MasterCard

Card #: __ __ __ __ - __ __ __ __ -__ __ __ __ -__ __ __ __

Expiration date: __ __ /__ __ Security code: __ __ __ (3-digit code located on the back of card)

Name (as printed on card): _____

Name of patient if credit card holder is not the patient: _____

I authorize Yujuan Choy, M.D. to charge the session fees to my above credit card for scheduled appointments:

$250 for a 25 minute medication management only appointment.

$300 for a 50 minute psychotherapy appointment.

Signature: _____ Date: _____
(Patient or financially responsible party)