351 Wagoner Dr STE 135
Fayetteville, NC 28303
888-550-2804
www.cateRRRflies.com

Credit Card & Insured Patient Responsibility Form

Please STOP & READ: Responsible Party Payment Information

In efforts to serve you best, a valid credit or debit card is required to be held on our secure system to reserve your 1st appointment and is maintained for future appointments per our policy and is used for no shows and late cancellations as well. If you are using as FSA card or an HSA card, please complete this form but be aware that you MUST ALSO complete a second form with a visa or debit card for charges that insurance is not responsible for. If you have questions or need support email info@caterrrflies.com.

Again, in efforts to provide you with excellent service please complete this form regardless of whether or not you currently have insurance.

By signing, you agree that you are not misrepresenting any information that would hinder services being paid for. Additionally, by signing, you acknowledge that regardless of insurance benefits, you are responsible for all fees for you (or your minor child). As we may share insurance verification, we obtain prior, we are not held responsible in the event that they choose not to pay for any reason as stated in the Professional Disclosure Statement and the Insurance Carrier & Copay Agreement. If this were to occur the balance would need to be paid in full before services where to continue and if not paid is subject to collections and all costs associated with.

Name: _____ **Date:** _____

Patient Demographic Information

Patient Name:	**Social Security #:**
Street Address:	**Date of Birth:**
City, State, Zip Code:	**Home Phone:**
Gender:	**Work Phone:**

CateRRRflies LIFEWORK

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Email Address:	**Mobile Phone:**
Primary Physician:	**Psychiatrist (if any):**
Emergency Contact Person:	**Emergency Contact Phone:**
How did you hear about us?	**Marital Status:**

Credit Card Information

Responsible Party Name:	**Responsible Party SSN:**
Name on Credit Card:	**Relationship to Patient:**
Credit/Debit Card #	**Expiration:** **CVC:**
Street Address:	**Work Phone:**
City, State, Zip Code:	**Mobile Phone:**
Relationship to Patient:	**Type of Credit Card:**

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Insurance Information

IF YOU ARE NOT USING INSURANCE PLEASE WRITE ACROSS THE PAGE
"I AM NOT USING INSURANCE."

Primary Insurance:	**Policy Holder Name:**
Company Address:	**Policy Holder Date of Birth:**
City, State, Zip Code:	**Identification Number:**
Company Phone:	**Policy/Group Number:**
Employer:	**Policy Holder SSN:**
Secondary Insurance:	**Policy Holder Name:**
Company Address:	**Policy Holder Date of Birth:**
City, State, Zip Code:	**Identification Number:**
Company Phone:	**Policy/Group Number:**
Employer:	**Policy Holder SSN:**