CREDIT CARD ON FILE POLICY:

At Good Life Journey, Inc. as a convenient method of payment for the portion of services that your insurance doesn't cover, we set up an automatic payment system for your deductibles and co-pays. Your credit card information is kept confidential and secure and payments to your card are processed only after you have completed your appointment.

I authorize Good Life Journey, Inc. to charge the portion of my bill that is my financial responsibility to the following credit or debit card: Visa Mastercard

Credit Card Number _____

Expiration Date _____ /_____ Card Code (3 Digits on Back) _____

Cardholder Name _____

Zip _____

I (we), the undersigned, authorize and request Good Life Journey, Inc. to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me at Good Life Journey, Inc.

Patient Name (Print): _____

Patient Signature: _____ Date: _____