

CREDIT / DEBIT CARD MANDATE FOR THIRD PARTY FUNDED PATIENTS ONLY
The information you provide here is strictly confidential.



For ease of administration we respectfully request that all patients receiving treatment funded by their medical insurer or other third party complete the following credit / debit card mandate to cover possible insurance shortfalls, policy excesses, late cancellation or missed appointment charges etc. In the event of any charges made against your card we will forward a receipt to you.

When receiving funded treatment it is your responsibility to be aware of any limits set by the funding body for numbers of treatment sessions or available funds and ensure that all treatment sessions fall within these agreed limits.

If you do not wish to complete this mandate we will not bill your insurance company and you will be required to pay for treatment at the end of each session. We will provide you with a ~~paid~~ invoice+for you to claim back the money from your insurer.

Please be assured that your credit / debit card details will be treated with the utmost confidentiality and security. This form will be kept separate from your treatment notes in a secure place only accessible by senior practice management staff. We will keep your credit / debit card details for 12 months after your have finished your insured treatment.

YOUR NAME

DATE OF FIRST APPOINTMENT

NAME OF INSURANCE CO. / FUNDING BODY

MEMBERSHIP / POLICY / REF NUMBER

AUTHORISATION NO.

CARD TYPE (e.g. mastercard. Maestro,etc)

CARD NUMBER

START DATE

EXPIRY DATE

ISSUE NO. (MAESTRO)

LAST THREE DIGITS ON THE BACK OF CARD

NAME PRINTED ON CARD

ADDRESS THAT CARD IS REGISTERED AT (if different from address given on registration form)

By signing this form I agree to my card being charged for any of the following:

- **Charges for which I am responsible that are associated with my insurance policy. This includes excess payments, limitations in benefits, claim denials and any other short falls in benefit.**
- **The cost of my treatment in the event that my insurer has denied or delayed payment due to insufficient documentation required by them from me.**
- **Applicable cancellation or missed appointment charges that are not covered by my insurance / funding body in the event that I fail to attend or give less than 24 hours notice.**

Signature: _____ Date: _____