Erik Gustke, M.D., PLLC

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To Be Completed for Administrative and Billing Purposes:
(All requested information is REQUIRED to receive further care and/or appointments)

Person Responsible for Payment: _____ Relation to Patient: _____

Phone Number (Preferably Cell Phone): _____

E-Mail of Person Responsible for Payment: _____

I, _____ ,hereby authorize medical treatment by Erik Gustke, M.D. and agree to assume full responsibility for fees for these services.

Fees include regular scheduled appointments, phone calls lasting more than five minutes, medication refills outside of scheduled appointment time, letters, other paperwork, preauthorization of medications, missed appointments (per the office policy of 72 hour notification), returned checks, and time spent in collaboration with other health care providers or individuals within the circle of care. A current schedule of fees is available upon request.

I am aware that payment is due at the time of the appointment. Payment may be in the form of cash or check. Payment may also be in the form of credit card (Visa/ MasterCard/ Discover Card). I am aware that failure to pay at the time of the appointment in the form of cash or check will result in my credit card being charged the appropriate amount on the day of the scheduled appointment. Certain fees, such as those incurred from missed appointments and phoned in medication refills, will be charged using the credit card on file. I am aware that the signature below authorizes Erik Gustke, M.D. to keep my credit card and signature on file and to use the credit card for the above mentioned charges if necessary or directed to do so. I am aware that this form is valid and I authorize charges as necessary unless I cancel the authorization in written notice.

Credit Card Information Must be filled out completely unless special circumstances are discussed with Dr. Gustke

Credit Card Type (Please Circle): Visa MasterCard Discover Card

Card Holder's Name (As it appears on card): _____

Card Holder's BILLING Address w/ ZIPCODE: _____

Credit Card Number: _____

Expiration Date:_____ / _____ 3 Digit Code on Back of Card (CVA#): _____

Signature of Card Holder: _____ **Date:** _____

Should it become necessary, I authorize Erik Gustke, M.D. to release and exchange in verbal and/or written form any information necessary for the payment of fees, and/or the provision of my medical care. This may include information related to alcohol or substance abuse. In addition, should it become necessary to need the services of a collection service or an attorney to secure payment, I am aware that I will be responsible for all costs, attorney fees, and other related expenses to the collection effort.

I have read this form completely and I am agreeing to the conditions set forth in this form and within the policies of the office of Erik Gustke, M.D.

_____ _____ / _____ / _____

Signature of Patient (and Parent if patient is a minor) **Date**