LA Alternative Medical Center

8631 W. 3rd St. #444E Los Angeles, CA 90048
5363 Balboa Blvd., #326 Encino, CA 91316
Tel: 310-360-0116

Informed Consent Form

Date:

Patient Name:

This document is to act as a set agreement for an approved payment plan based upon policy set by LA Alternative Medical Center.

The patient listed above will agree to this payment plan as prescribed below for the patient's outstanding account balance. Should the patient deviate from the prescribed plan at any time (including but not limited to: missed payments, late payments, declined payments or payments not made in full) LA Alternative Medical Center reserves

the right to charge interest, penalties or consider delinquency at any time. For this reason, LA Alternative Medical Center requires the patient to file credit card information for automatic payments to be made as outlined by the payment plan.

LA Alternative Medical Center requires the patient to sign this form agreement stating that they will send reimbursement checks that the patient receives from their insurance company back to the provider to settle out their balance. If payment is not received, LA Alternative Medical Center reserves the right to charge the credit card.

Please sign and return this original document. The signature of this document denotes that all parties agreed to the terms of this arrangement.

Patient Signature _________________

Date __________________

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _______________
Cardholder Name (as shown on card):
Card Number:
Expiration Date (mm/yy):
Cardholder Zip Code (from credit card billing address):

I, ________________________, authorize ________________________ to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

____________________________________ __________________________________

Patient Signature Date