mentem
PSYCHIATRY

CREDIT CARD AUTHORIZATION FORM

Mentem Psychiatry requires a credit card be kept on file for payment of any co-payment, co-insurance, deductible, or charge that may not be covered by your health insurance such as no-show fees. This form will be kept confidential and only authorized staff will have access to the information.

PATIENT NAME: _____

NAME, AS IT APPEARS ON CARD: _____

BILLING ADDRESS: _____

_____

EMAIL ADDRESS: _____

CARD #: _____

EXPIRATION DATE: _____ /_____ **VERIFICATION CODE:** _____

I acknowledge and authorize Mentem Psychiatry to charge the above credit card account for any co-payment, co-insurance, deductible and/or charges not covered by my health insurance provider such as no-show fees. I acknowledge that my card will be run in the event payment is not received in a timely manner. I agree to receive billing statements, invoiced, and receipts via the email and/or address I have provided to Mentem Psychiatry. If I am uninsured, I authorize payment at time of service. I agree to update any information regarding this credit card account.

_____ _____

Cardholder Signature Date