Mid Cities Psychiatry

Pre-Authorized Payment Plan Form

Name

DOB ☐ Male / ☐ Female Under 18 ☐ Yes / ☐ No

Address

Tel # e-mail

☐ Cash ☐ Cheque ☐ Credit Card ☐ Debit Card

Name of Card Holder			
Card # (last 4 digits only)	XXXX-XXXX-XXXX-		
Card Expiration Date		Card Security Code	XXX

I, hereby authorize Mid Cities Psychiatry to debit my/our credit card account each month as per the following payment schedule. This authorization will cease after the last payment is made.

The treatment of each payment shall be the same as if I/we had personally made the payment using my/our credit card.

I/we are responsible for maintaining the credit card to be valid to be charged for the purposes of paying the monthly payments to Mid Cities Psychiatry.

I understand and agree in case of a missed payment of this payment-plan, I will be assessed a late charge of $25.00 and additional late charges of $3.00 per day thereafter until the payment plan installment and late charges are paid in full at least 5 business days before the next appointment or all the next appointments will be canceled. Additional late charges not to exceed 15 days and thereafter all next appointments will be canceled unless full balance amount is paid in cash or approved CC payment before the next appointment can be scheduled. If full balance amount is not paid in cash or approved CC payment in these 15 days; **the account will be placed in collection and my Psychiatrist-Patient relationship will be terminated**.

_____
Initial please

Total Amount Beginning Balance $_____

Cheque #s	Payment Date	Payment Amount	Balance

_____ Name of Patient _____ Date of Birth

_____ Name of Credit Card Holder _____ Date

_____ Signature of Credit Card Holder _____ Date

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