Patient Easy Pay Consent Form

Patient Name: _____
Last First Middle Initial

I authorize **Mind Opener Psychological Services, Inc**. to charge my credit card for payments remaining on my account or delinquent payments that are 30 days mature without a formal payment agreement in place. This charge could be for the balance of fees not paid by my insurance company within 30 days from the balance of charges after an explanation of benefits is received from my insurance company, which may include co-pays, co-insurance deductible balances, etc. Or it could be due to missed appointments that were either canceled too late, no shows, or balances owed for miscellaneous expenses (i.e. testing, letters written on my behalf, telephone consults that expand past ten minutes, returned check charges, etc.).

I understand that this form is valid until the expiration date of my charge card listed on this form, unless I cancel the authorization through written notice.

Mind Opener Psychological Services, Inc will appear on my credit card statement Initial _____

Name on the card _____ **Phone** _____

Billing address_____

City _____ **State** _____ **Zip Code** _____

Master card/ Visa/Amex **CCV** _____

Account # _____-_____-_____-_____ **Exp Date** _____

Card Holders
Signature _____ **Date**_____