Manifest Psychiatry PLLC

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CREDIT CARD ON FILE AGREEMENT

Manifest Psychiatry PLLC **practice policy now requires keeping a Guarantor credit or debit card on file for every patient account** as a convenient method of payment to collect for services for which you are responsible financially. Keeping a credit card on file will eliminate waiting for statements, mailing checks, or calling with credit card payments.

This agreement is required- if you chose to decline this authorization or do not maintain a valid and current credit card on file, billing and unpaid balance fees, and further actions will be implemented as outlined in the practice Financial Policy.

Your credit card information will be kept confidential and secure. No credit card information will be kept on file in the office. Your information will be maintained through an independent merchant services vendor called *PayJunction/Elation* in a secure, encrypted, and fire walled program that is fully compliant with the Payment Card Industry Data Security Standard (PCI-DSS). *PayJunction/Elation* is designated as a Level 1 PCI Compliant Provider as well as a HIPAA Compliant Provider. Card numbers are not visible to the practice with the exception of the last 4 digits.

Payment terms:

o Out-of-pocket expenses incurred during patient visits will be charged to credit card on file after the completion of the appointment (unless another form of payment is agreed upon and paid at the at the time of the service).

o Out-of-pocket charges incurred between visits will be charged to the credit card on file immediately (unless another form of payment is agreed upon and promptly paid). Please understand that out-of-pocket charges also include no show/ late cancellation fees.

o Fees for services rendered can be estimated for each patient prior to any visit by the physician, but exact charges may not be available until after the service has been completed. Please feel free to discuss concerns regarding this with your doctor at any time!

Patient(s) covered by this Credit Card on File Agreement:

_____ ___/ ___/ ___

Patient Name DOB

_____ ___/ ___/ ___

Patient Name DOB

_____ ___/ ___/ ___

Patient Name DOB

_____ ___/ ___/ ___

Patient Name DOB

This authorization will remain in effect until I cancel this authorization. To cancel, I must give a 60 day notification to Manifest Psychiatry PLLC in writing and the patient account(s) must be in good standing. Card expiration dates must be kept updated and will not void this written agreement.

I, the undersigned, authorize SHIPS to charge all patient charges that are my financial responsibility, as outlined above, to the following credit or debit card:

☐ Visa ☐ Mastercard ☐ Discover ☐ AMEX

_____ _____ _____ _____ _____ / _____

Last 4 digits of credit card number Expiration Date

PRINT Cardholder Name_____

Signature_____

Date___/ ___/ ___