MERIDIAN
PSYCHIATRIC
PARTNERS LLC

MERIDIAN CREDIT CARD AUTHORIZATION

I, ______________________________________, hereby authorize Meridian Psychiatric Partners, LLC, to charge my credit/debit card for any account balance that is more than 60 days past due.

____ PATIENT INITIALS

I understand my card will be charged on a regular basis for these amounts. I also understand that in the event my card declines, I will be required to provide a different method of payment. I will also be expected to pay for any previously unpaid charges resulting from the decline, in addition to the current charges.

I authorize my card to be charged for fees as indicated above.

____ PATIENT INITIALS

Credit Card Number:____

Exp. Date: ____________ **CVV Code** ____________

Billing Address for the Debit/Credit Card listed above:
____
____
Patient Name: ____
Patient Signature: ____ **Date:** _______________

AUTOMATIC BILLING

Additionally, for your convenience, if you wish to have your balance charged to your credit/debit card for any patient responsibility from services rendered (deductibles, co-payments, and co-insurances) and/or fees incurred (cancellations within 24 hours or no-show appointments) after each visit, please check the auto-charge box and initial below.

☐ Yes, charge this credit card for my balance regularly.
____ PATIENT INITIALS

STATEMENT INFORMATION

You will receive statements from Meridian Psychiatric Partners by US mail.

Signature ____ Date ______________________