Psychiatric Medical Associates, P.A.
6404 International Pkwy, # 1010, Plano, TX 75093
Phone # 972-267-1988
Fax # 972-267-3434

CREDIT CARD ON FILE POLICY

At Psychiatric Medical Associates, P.A., we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable, especially when you are receiving services virtually. Without this authorization, a billing fee of $25 will be added to your account for any balances that we must attempt to collect through mailing monthly statements. Furthermore, an "outstanding balance" charge of 1.5 percent of the total bill will be charged for each month that the bill remains unpaid.
Your credit card information is kept confidential and secure and payments to your card are processed on the day of your appointment based on your insurance benefits for any amount that is deemed patient responsibility by your insurance. Occasionally when we do not have benefit information available on the day of your appointment, we will charge the credit card for your balance after the claim is processed by your insurance.

I authorize Psychiatric Medical Associates, P.A. to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Credit Card Number _____

Expiration Date _____ / _____ CVV # (Security code on back of card) _____

Cardholder Name _____

Billing Address _____

City _____ State_____ Zip _____

Signature _____ Date _____

I (we), the undersigned, authorize and request Psychiatric Medical Associates, P.A. to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.
This authorization relates to all payments not covered by my insurance company for services provided to me by Psychiatric Medical Associates, P.A.
This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to Psychiatric Medical Associates, P.A. in writing and the account must be in good standing.

Patient Name (Print): _____ Legal Guardian Name (Print):_____

Patient Signature: _____ Legal Guardian Signature: _____

Email this form to - documents@pmaplano.com