PREMIER
PSYCHIATRIC & SLEEP MEDICINE ASSOCIATES
Healing Minds • Restoring Sleep

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Patient Credit Card on File Agreement

We have implemented a policy which enables you to maintain your credit card information securely on file. In providing us with your credit card information, you are giving Eximious Integrated Health Solutions permission to automatically charge your credit card on file for your [or any other patient(s) you have listed on this form] co-pay, outstanding balance and fees; $75.00 for no show and $75.00 for late cancellation. By signing this you authorize this agreement will remain in effect until the expiration of the credit card account and this authorization will remain in effect until cancelled. You may cancel this authorization by contacting our office by phone and/or email.

Co-pays*:* Co-pays are due at the time of appointment. Any deductible balances must be paid prior to the next appointment.

Outstanding Balance: If your insurance provider has paid their portion of your bill [or any other patient(s) you have listed on this form] and there is an outstanding balance owed you will be contacted via phone and/or email. If by the final billing notice, we do not receive a response from you or your payment in full, at that time, any balance owed will be charged to your credit card.

Multiple Users: This card will only be authorized for the use of the credit card holder, his/her minor(s), or any person(s) listed below.

Visa	**MasterCard**	**Discover**	**HSA**
☐	☐	☐	☐

Credit Card Holder's Name: _____
(as shown on card)

Card Number: ____ _____ _____ Billing ZIP Code: _____

Expiration Date: _____ CVV: _____

If you wish to leave this credit card on file for other patient(s), please print name(s) below:

Patient Full Name: _____ Relationship: _____
(Please Print)

Patient Full Name: _____ Relationship: _____

Patient Full Name: _____ Relationship: _____

Patient Signature: _____ Date: _____