Payment Methods

Patient Name:_________________________________DOB:_______________

Cardholder Name:_______________________________ Relationship:_____________

WE DO NOT CARRY PATIENT BALANCES.
ALL FEES ARE DUE AT THE TIME OF SERVICE.
A VALID CREDIT CARD OR DEBIT CARD IS REQUIRED BY ALL PATIENTS.

★ In the event of a missed appointment without proper 24 hour cancellation, please charge fees to the following card

___Visa___MasterCard___Discover___American Express

Name (as it appears on your credit card)_______________________________________
Card Number_______________________________________Exp Date:____________
3 Digit security code on the back of card (CVV)____________
Billing address____
Billing Zip Code_______________
Cardholder Signature____

Please note: You must inform the office if there have been **ANY** changes to your credit card information. Failure to inform the office of such changes or a declined credit card transaction will result in a $25.00 charge to your account.

By signing below, you agree to, approve, and understand all of the following:

- Carolina Complete Psychiatry, PLLC, reserves the right to charge the credit card on file, at any time for service provided by the company, **with verbal consent from client.**
- If your account at Carolina Complete Psychiatry, PLLC. carries an outstanding balance for more than 30 days, we may charge the card for the outstanding amount without giving prior notice.
- You have the right to request an invoice/statement at any time.
- Carolina Complete Psychiatry, LLPC. will not be held liable for any fraudulent charges made to the credit card account.
- If you are not the cardholder of the credit card, you agree to take full responsibility for any charges made by Carolina Complete Psychiatry to the card you have provided.

Patient Signature______________________________ Date______________________