Gladstone
Psychiatry and Wellness

Consent to Charge Credit Card

Patient Name: _____ Patient Date of Birth: _____

As part of Gladstone Psychiatry's billing policy, fees associated with appointments will be charged automatically within 24 hours of the appointment.

1) You will receive an email and a text 24 hours before your card is charged letting you know the total and the timing of the charge.
2) If you do not want your credit card to be charged, you must respond to our billing office by text, email, or phone to alert them not to charge.
3) If your credit card is expired or does not work, you will be alerted asking you to provide new card information.
4) Note that if a balance accumulates on your account that is over 120 days, it will be sent to FedChex collections agency.

Please print and sign your name below to acknowledge your receipt, acceptance, and understanding of Gladstone Psychiatry's Telemedicine Payment Agreement.

_____ (Initial) I, the undersigned, hereby authorize Gladstone Psychiatry and Wellness to deduct any payments/balance due for my telemedicine appointment from the debit/credit card account provided on this agreement.

_____ (Initial) I have been provided the opportunity to discuss my questions and/or concerns about this payment agreement with Gladstone Psychiatry staff. I understand that I am able to contact the Billing Department at Gladstone Psychiatry & Wellness at any time with further questions.

_____ (Initial) I understand that all balances must be paid at the time of service.All balances that remain unpaid in accordance to this agreement will be considered for a thirty-party collection agency.

_____ (Initial) I understand that I will be notified via phone, email, or mail, if Gladstone Psychiatry & Wellness is unable to process my payment. No less than two attempts will be made by Gladstone Psychiatry & Wellness to collect payment in a timely manner. I understand that no further telemedicine appointments shall be scheduled until payment is made in full or a payment arrangement is formed. I understand that if I am a self pay patient, my appointments will be paused until I pay the balance or set up a payment plan.

_____ (Initial) I agree that it is my responsibility to contact the Billing Department at Gladstone Psychiatry & Wellness if any changes need to be made to my billing information.

_____
Patient Name or Name of Parent / Legal Guardian (Printed)

_____ / _____
Patient Signature or Parent/Legal Guardian Signature Date

IF YOU DO NOT WISH TO PROVIDE CREDIT CARD INFORMATION, PLEASE SIGN STATEMENT BELOW (and put NA in all the above fields):

_____ (Initial) I, the undersigned, acknowledge that I **choose to opt out** of Gladstone Psychiatry automatic payments for appointments as outlined above.

_____ (Initial) I recognize that it will be my responsibility to contact Gladstone Psychiatry to provide payments for my appointments.

_____ (Initial) If I fail to do so, after 120 days my balance will be sent to FedChex CollectionsAgency.

_____

Patient Name or Name of Parent / Legal Guardian (Printed)

_____ / _____

Patient Signature or Parent/Legal Guardian Signature Date