Regional Psychiatry
9100 Conroy Windermere Rd, Suite 269, Windermere FL, 34786
Tel: 407-462-1254 / Fax: 407-604-6614

PLEASE COMPLETE THE BELOW INFORMATION TO PLACE A CREDIT CARD ON FILE FOR PAYMENTS

Patient Name:_____ Date of Birth: _____
First Middle Last

Billing Information:

Accountholder Name:_____

Account Billing Address _____
_____

City_____ State_____ Zip _____

Account Phone _____

Card # _____
Exp: _____/ _____ Security Code on Back of Card (3 or 4 digit) _____

Email if you would like receipts: _____

I hereby authorize Regional Psychiatry physician and staff to keep my account information on file for payment and to initiate debit or charge entries on this account as amount are owed for the Patient Account listed above. I acknowledge that the origination of ACH or credit card transactions to my account must comply with the provisions of U.S. law. I understand that a debit or charge may be made to my bank account or credit card account periodically to pay for amounts owed including cancellation no show fees, copayments, deductibles. If my bank account or credit card information listed above changes for any reason, I will notify my Regional Psychiatry physician and / or staff team. This authorization shall remain in effect until the patient doctor relationship between myself and my Regional Psychiatry provider has ended, or when my provider has received written notification from me of its termination.

X_____ Date: _____
Cardholder