MTI PSYCHIATRY

PAYMENT INFORMATION FORM

PATIENT INFORMATION

PATIENT NAME	DATE OF BIRTH

ADDRESS	PHONE NUMBER

CREDIT CARD | DEBIT CARD INFORMATION

Please complete all fields. You may cancel this authorization at any time by contacting our office. This authorization will remain in effect until it is cancelled. Your Credit Card or Debit Card information is kept in your secure Luminello patient portal for the entire duration of treatment. Unless other arrangements have been made, your credit card or debit card will be charged for the initial consultation, each appointment, administrative work, and cancellation/no show fees.

CHOOSE ONE:	☐CREDIT CARD		☐DEBIT CARD		
CHOOSE ONE:	☐VISA	☐MASTERCARD	☐AMEX	☐DISCOVER	☐OTHER
NAME ON CARD:					
CARD NUMBER:			**EXPIRATION DATE:**		
					MM/YYYY
CVV:					
	THREE- OR FOUR-DIGIT NUMBER ON BACK/FRONT OF CARD				
BILLING ADDRESS:					
	Street	*City*	*State*	*Zip*	*Country*

I, the undersigned, authorize MTI Psychiatry, Inc. to charge the payment method provided above for all services rendered as outlined in the PAYMENT POLICY AGREEMENT. I understand that it is my responsibility to notify MTI Psychiatry, Inc. of any changes to my payment information. If my account becomes delinquent, I understand that I may be responsible for additional fees, including collection costs and legal fees. I understand that my information will be saved for future transactions. I have read and I understand all the rates and fees outlined in the PAYMENT POLICY AGREEMENT. I affirm I am an authorized user of the payment method indicated above.

PATIENT SIGNATURE	DATE

GUARDIAN/REPRESENTATIVE SIGNATURE *(If applicable)*	RELATIONSHIP TO PATIENT	DATE