NCI CREDIT CARD AUTHORIZATION FORM

(Mandatory for all new patients.)

PATIENT NAME: _____ DATE OF BIRTH: _____

The purpose of this form is to authorize Neuropsychological Consultants, Inc (NCI) to retain a valid credit card number on file for you as our patient. **All new patients are required to complete this form.** This form will be kept confidential, and only authorized staff have access to the information.

It is NCI's policy to send **ONE** statement to the patient or parent/guardian indicating the balance due on their account following receipt of insurance payment(s). If no payment is received by the time of the due date on the statement (30 days from issue), we will assume that you wish to pay your bill with the credit card on file. This notice serves as your consent to being charged for all current patient balances on your account at that time.

This is the ONLY circumstance in which your credit card will be charged. In conjunction with HIPPA regulations, all credit card information will be confidentially kept within your medical chart. Only authorized staff will be able to access this information.

Acknowledged, Agreed, and Accepted:

Having read this form and talked with my doctor and/or staff, my signature below acknowledges that I voluntarily give my authorization and consent to providing the requested information for my credit card to be charged accordingly for the condition listed above.

X _____ X _____

Patient Signature Date Staff Signature Date

(or person authorized to sign for patient)

NAME, AS APPEARS ON CREDIT CARD:_____

BILLING ADDRESS:_____

_____

AMEX/DISC/MC/VISA: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

EXPIRATION DATE: ___/___ VERIFICATION CODE (3 or 4 DIGITS): ___ ___ ___ ___

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Refusal to Complete Authorization:

*Refusal to complete and agree to this authorization dictates the following: Since there is no credit card on file with NCI, NCI reserves the right to send only **ONE statement** to the address on file to notify you of your balance with our practice. It is your responsibility to send the amount due by the due date on the statement to avoid being sent to collections and having your account closed with our practice.*

X _____ X _____

Patient Signature Date Staff Signature Date

(or person authorized to sign for patient)