New England Center
for healthy minds

Authorization for Credit Card Use

PRINT AND COMPLETE THIS AUTHORIZATION AND RETURN TO: New England Center Billing Dept, 289 Great Rd Ste G1, Acton, MA 01720

All information will remain confidential in compliance with the Standards for the Protection of Personal Information of Residents of the Commonwealth (201 C.M.R. 17.00)

I authorize New England Center for Healthy Minds to charge the following to the credit card on file, until such time as I request, in writing, to terminate this agreement.

- Any amounts outstanding over 90 days.
- I am beginning TMS therapy. Deductible/copay/coinsurance balances will be auto charged on my account weekly on the following day (Please circle): M T W Th F
- Any amount applied to my deductible.
- Payments as per agreement for payment plan:
  Auto-charge the amount of $_____ on the _____ of every month for _____ months.
- Auto-charge copayments due at the time of service.
- Any other balances not covered by insurance, including fees associated with no showed appointments, appointments cancelled within 48 hours, urgent refills, and medical records/special documentation requests.

I agree to pay for any and all purchases in accordance with the issuing bank cardholder agreement.

Patient's Name and DOB: _____

Cardholder Information:

Name on Card: _____

Billing Address: _____

_____

Credit Card Type: ___Visa ___MasterCard ___Discover ___AMEX

HSA or Flex Spending? Yes_____ No_____

Credit Card Number: _____

Expiration Date: _____

Card Identification Number: _____ (3 digits located on the back of the credit card)

Print Name: _____

Signature: _____

Date: _____