Neogen Psychiatry,P.A.

Child, Adolescent and Adult Psychiatry
2141 Kirkwood Blvd, Ste 130, Southlake, TX 76092
Ph: (817) 442-3112; FAX: (817) 251-8844

Patient's Name: _______________________Date of Birth: _____________

CREDIT CARD AUTHORIZATION

To initiate payment by credit card an imprint of your credit card is required. Your credit card information will be kept on file. If you have an outstanding balance on the last day of the monthly billing cycle, your credit card will automatically be billed.

If you would prefer to pay by credit card, please list below:

PLEASE CIRCLE ONE: VISA MASTERCARD DISCOVER

Credit Card No: ____

Name as written on card: _______________________________________

Expiration Date: Month_____ Year_____
3 Digit Security Code on Back of card _______

Billing Address and Zip Code for the card: ______________________

I hereby give my authorization and consent for the above listed card to be used for payment to Gene Fletcher, D.O., P.A. The billing charge will reflect the service rendered per the office policy and will be itemized on the monthly billing statement. I understand that I am financially liable for fees incurred due to failure to cancel appointments 24 hrs in advance. (Please be aware that the date(s) listed on your credit card statement will reflect the date of processing the charge, not necessarily the actual date of service, since not all fees are processed on the date of service.)

Signature: _____________________________ Date: ________________