



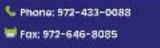
Payment Plan Financial Card Policy Consent

I _______ authorize Reliant Family Psychiatry to keep my credit card/debit card indicated below on file & to be drafted automatically for my payment plan agreement. The amount will be charged the morning of the scheduled payment dates. I understand this signed consent constitutes the ONLY notice of payment withdrawal from my account. I am signing this agreement knowing that I will not be given advance notice before the payment is charged. Only the amount agreed on the payment plan will be automatically charged. I understand that I will be contacted separately to set up payments for new balances owed, if any occur on my account. **Credit Card Holders Name (As shown on card):**

Card Number:	
Billing Zip Code:	
Expiration Date on card://	
CVV (Security Code on Card): Balance:	
Payment Amt:	
#Of Payments:	
Start Date:	
Card Holder's Signature://	Date:
Card Holder's relation to patient:	
Patient Signature :	Date :
//	
Patients Guardians Signature:	Date
:/	



l contact@reliantpsychiatry.com 929 W Pioneer Pkwy, Suite A Grand Prairie TX 75051









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Patients Guardians Signature:	Date :///////
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