RELIANT FAMILY
Comprehensive Psychiatry Services

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** :_____/_____/_____

contact@reliantpsychiatry.com
929 W Pioneer Pkwy, Suite A
Grand Prairie TX 75051
Phone: 972-433-0088
Fax: 972-646-8085

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Credit Card Holders Name (As shown on card): _____

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