TRUENORTH PSYCHIATRIC NURSING CORP

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PAYMENT AUTHORIZATION

Card-on-File & Payment Authorization

Authorization for patient-responsibility charges. This form does not change your insurance benefits or coverage.

PATIENT & CARDHOLDER INFORMATION

Patient Name: _____ Date of Birth: _____

Cardholder Name: _____ Relationship to Patient: _____

Billing Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Email: _____

PAYMENT METHOD

For security, enter only the payment details requested by your practice's secure payment system.

Card Type: ☐ Visa ☐ Mastercard ☐ American Express ☐ Discover ☐ Other

Last 4 digits: _____ Expiration (MM/YY): _____

Do not enter a full card number or CVV on this form unless your secure payment processor specifically requires it.

AUTHORIZATION

I authorize TrueNorth Psychiatric Nursing Corp to securely maintain my payment method through its payment processor and charge it for amounts I owe for healthcare services. Charges may include copayments, coinsurance, deductibles, self-pay fees, and other patient-responsibility amounts described in TrueNorth's Financial Policy.

This authorization does not permit TrueNorth to charge amounts I do not owe, waive applicable billing laws, or override my rights under my health plan or applicable law. Insurance estimates and benefit verification are not guarantees of payment.

Choose ONE authorization option:

☐ OPTION A - Card on file: charge amounts due after services are provided or claims are processed.

☐ OPTION B - Recurring balance payment: charge outstanding patient-responsibility balances according to the billing schedule in the Financial Policy or other written notice provided to me.

NOTICE, RECEIPTS & DISPUTED CHARGES

I understand that charge amounts and timing may vary based on services, insurance processing, and my patient balance. TrueNorth will provide a receipt or account record through its billing process. I agree to keep payment information current and contact TrueNorth promptly if I believe a charge is incorrect.

Nothing in this authorization waives my lawful right to question or dispute an incorrect or unauthorized charge. I remain responsible for valid balances owed under the Financial Policy and applicable law.

CANCELLATION OF AUTHORIZATION

This authorization remains effective until I revoke it. I may revoke it prospectively by providing notice to TrueNorth through an accepted practice communication method. Revocation does not affect charges already processed or valid balances already incurred. After revocation, I remain responsible for arranging another method of payment for amounts I owe.

CARDHOLDER AUTHORIZATION

I certify that I am the cardholder or an authorized user of the payment method identified above. I have reviewed this form, understand the authorization selected, and authorize TrueNorth to process payments according to these terms and the Financial Policy.

Cardholder Printed Name: _____ Date: _____

Cardholder Signature: _____

Type full legal name as electronic signature if completing electronically.