PAYMENT CONSENT FORM

Client Name _____
Last First Middle

I agree to be responsible for full payment of my bill due to Mind Body Connections. I understand that Mind Body Connections prefers to receive payment in the form of check or cash. I also understand that Mind Body Connection may charge my credit card for any unpaid or overdue balances. I agree to provide a current, valid credit card for this purpose. I understand that charges may appear on my credit card statement as Professional Charges, Square, or Mind Body Connections, LLC. I authorize Mind Body Connections, LLC to charge my credit/debit card for professional services as follows:

Please Initial

_____ This visit only, for the amount of $ _____.

_____ All visits in the next 12 months, beginning _____/_____/_____ not to exceed $_____ total.

_____ Recurring charges, date(s) of service _____/_____/_____ to _____/_____/_____, not to exceed $_____.
_____monthly, _____semimonthly, _____weekly, _____per visit.

_____ **To charge my card for the balance of fees not paid by my insurance company within 90 days.**
(*required*)

Type of Card:
_____ Visa _____ MasterCard _____Discover _____Medical Flex/Savings

Name as it appears on Card _____

Card Holder's Address _____

Credit Card Number _____-_____-_____-_____, CVV Number _____
A 3-digit number on the back of credit card

Expiration Date _____

Card Holder Signature: Date: