



Whole Life Psychiatry

Kim D. Tubbs, PMHNP, PA, Inc.

CREDIT CARD ON FILE POLICY

Kim Tubbs, PMHNP requires your credit or debit card to be kept on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Without this authorization, a billing fee of \$25 will be added to your account for any balances that we must attempt to collect. Furthermore, an outstanding balance charge of 1.5 percent of the total bill will be charged for each month that the bill remains unpaid.

Your credit card information is kept confidential and secure, and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has been paid and posted to the account.

I authorize Kim Tubbs, PMHNP, PA, Inc. to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

Visa Mastercard Discover

Credit card number _____

Expiration date __/____

Cardholder name _____

Cardholder signature _____

Billing address _____

City _____ State _____ Zip _____

I, the undersigned, authorize and request Kim Tubbs, PMHNP, PA, Inc. to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by Kim Tubbs, PMHNP.

This authorization will remain in effect until I cancel this authorization. To cancel, I must give a 60 day notification to Kim Tubbs, PMHNP in writing and the account must be in good standing.

Responsible party name (print): _____

Responsible party signature: _____

Date: __/____/____