

Credit Card Authorization

Ravi Kant, MD, P.C.

300 Old Pond Road, Suite 201, Bridgeville, PA 15017

Please complete all the fields. You may cancel this authorization at any time by contacting us in writing. This authorization will remain in effect until cancelled.

Patient Name:_____ **Patient Date of Birth** _____

Cardholder's Name - Last_____ First _____

Card type – Visa___ MC ___ AmEx ___ Discover _____

Last 4 digits of Credit Card _____ Exp Date _____(mm/yr) CVV _____

Billing Zip Code_____

Please call the office to give full credit card info or add it at your **MYIO App** account

I hereby authorize **Ravi Kant MD PC dba NeuroPsychiatry Center** to charge my credit card listed above or entered in the portal account for services provided to my family member/s, dependents and/or myself. This can include self-pay fees, co-payments, deductible, No-Show and/or late cancellation fees, and services not covered under my insurance, but I agreed to receive. I understand my credit card will not be charged more than \$500 at one time. I understand that my information will be saved on file for future transactions on my account. I am responsible for keeping this information updated in a timely manner. This authorization will apply to any credit card updates in the future. I am aware that NeuroPsychiatry Center will be unable to notify me before processing this card on file and that my card may be charged at any time at the discretion of NeuroPsychiatry Center for the reasons listed above. I will be responsible for any and all associated credit card fees if I cancel the payments charged through my bank or credit card company.

These circumstances DO NOT apply to medical assistance recipients.

I certify that this data is true, correct & accurate. Any false claims, documents, or concealment of material facts may be prosecuted under applicable laws. Under penalty of perjury, I herewith affirm that my electronic signature, and all future electronic signatures, were signed by myself with full knowledge and consent and am legally bound to these terms and conditions.

Patient/Guardian/Responsible party signature

Sign *X_____ **Date:**_____