GREATMINDS

...fostering success in development, learning and living

Credit Card Payment Consent Form

Please complete and fax to: (855) 847-7656

Patient Name ____
Print Last *First* *Middle Initial*

Name on Card if different ____

I authorize *Dr. Janet S Reed, Great Minds of Michigan PLLC,* and *ProfessionalCharges.com*, to charge my credit/debit card for professional services as follows:

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 30 days, as indicated above.**

Type of Card: ☐ Visa, ☐ MasterCard, ☐ Discover.

Credit Card Number _______ - _______ - _______ - _______, CVV Number _________
A 3-digit number in reverse italics on the **back** of the credit card

Expiration Date _____________

Card Holder's Billing Address for Credit Card Statements

____
Street City State Zip

If I have questions about these charges, I agree to contact my provider and if necessary ProfessionalCharges.com via email (info@professionalcharges.com). I agree that I will not pursue a refund directly through my credit/debit card company, bank, or financial institution. If any of my actions yield a chargeback for any reason, I agree to pay any and all penalty fee(s) incurred by my provider.

Card Holder Signature ___________________________________, Date ____ /_____ /____

Charges will appear on your credit card statement as an abbreviation of

ProfessionalCharges.com