EAST SIDE TMS AND WELLNESS CENTER

INFORMED CONSENT & AUTHORIZATION FOR CREDIT CARD TRANSACTIONS

By placing your electronic signature on this form, you authorize charges to your credit card for services rendered. You have the right to request a paper copy of this document, as well as copies of any payments charged to your card. By placing your electronic signature on this form, you agree to notify Eastside TMS and Wellness Center, LLC, of any changes in your account information or termination of this authorization in writing. In the case of a credit card transaction being rejected for Insufficient Funds, you understand that Eastside TMS and Wellness, LLC, may, at is discretion, attempt to process the charge again within 30 days.

☐ I authorize EASTSIDE TMS AND WELLNESS CENTER, LLC to charge my credit card for all patient responsibility amounts. I also agree that my credit card can be charged for any session that is not cancelled at least 48 hours prior to the scheduled session.

☐ I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify EASTSIDE TMS AND WELLNESS CENTER, LLC in writing of any changes in my account information or termination of this authorization.

☐ I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my bank or credit card company as long as the transactions correspond to the terms indicated in this authorization form. I acknowledge that credit card transactions could be linked to Protected Health Information.

_____ _____
Patient's Signature Date Signed

_____ _____
Cardholder's Signature (if not the patient) Date Signed

Patient Name _____ **Date** _____

Cardholder's Name (if different from patient) _____

Type of Card

- ☐ Visa
- ☐ Mastercard
- ☐ Discover
- ☐ American Express
- ☐ HSA
- ☐ Other

Credit Card Number _____

Expiration Date _____ **Security Code** _____

Billing Address _____