TRUE Mental Health & Wellness, PLLC
Trust. Rapport. Understanding. Encouragement.
15 Dawn Road, Suite 2, Pinehurst, NC 28374 | O:910-585-6108 F:910-475-1666 |
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PAYMENT AUTHORIZATION FORM

PAYMENT METHOD DETAILS

Payment Method: CREDIT CARD/DEBIT CARD

Name on Card:_____

Card Number:_____

Card Expiration:_____ Security Code:_____

Billing Address:_____

Billing Zip:_____

ACKNOWLEDGEMENT

TRUE Mental Health & Wellness, PLLC requires you to provide credit/debit card information on file with us so we can automatically charge any co-pays, co-insurance, deductible amounts and professional service charges. It is the patient's responsibility to keep cards accurate and up to date. We store financial information and other protected health information (PHI) in an encrypted, HIPAA compliant site. Payment is required at the time of service. We provide regular statements for your account balance via email or through the patient portal. You may pay your balance in session with your therapist, online via your patient portal, through our biller, or by VENMO, APPLE-PAY, check or cash. If balance accrues and no payment is received, we reserve the right to seek payment by any means, including using the credit/debit information we have on file, retaining the collection agency, and taking legal action in court. We may be willing to work out a patient payment plan that includes a reasonable period for resolving the balance. If the patient's balance remains unpaid, we reserve the right to suspend services until the balance is paid in part or in full. DISCLAIMER: By signing your name below, you agree that your signature is the legal equivalent of "I" on this document. By signing below, I certify that the above information is true and accurate and that I am an authorized user on the credit/debit account above. I authorize TRUE Mental Health & Wellness, PLLC to keep my credit card information on file and charge the above fees automatically and on an ongoing basis until or unless I cancel these automatic payments in writing. I understand that I am responsible for any charges incurred associated with declined cards, non-sufficient funds. By signing below, I am authorizing TRUE Mental Health & Wellness, PLLC to charge my credit/debit card for the following: Self-Payment fees for all individual or family counseling sessions OR Co-Pay or Co-Insurance rate(s) for all attended appointments AND any portion of billable services not covered by my insurance policy.

Signature: _____ Date: _____