Healing Minds Oasis
24300 Orchard Lk. Rd. Suite 3 Farmington Hills, MI 48336
Tel: (248) 537-2646 Fax: (248) 301-0550

Credit Card on File Agreement

We have implemented a policy which enables you to maintain your credit card information securely on file with Healing Minds Oasis (HMO). In providing us with your credit card information, you are giving HMO permission to automatically charge your credit card on file for your (and/or any other patients you have listed on this form) co-pays/co-insurance, outstanding balances, services, and/or products.

Co-Pays/Co-Insurance: Co-pays and co-insurances are due at the time of the office visit. You may still choose to make your payment by check, cash, or a card different from the credit card on file.

Outstanding Balance: If your insurance provider has paid their portion of your bill (or any other patients you have listed on this form) and there is still an outstanding balance owed, HMO will notify you via phone and/or mail. If the balance remaining is not paid in full within 7 days of the notice, at that time, any balance owed will be charged to your credit card. A copy of the charge will be mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment. Missed appointment and other non-insurance-billable fees will be charged at the time of the missed appointment or fee assessment. A receipt will be mailed to you.

Services and Products: Self Pay services and other fees are due at the time of the office visit.

This card will only be authorized for the use of the credit card holder or any person(s) listed below by the credit card holder. **This agreement will expire upon termination of services and settlement of final balance**. The card holder may also revoke this consent at any time in writing while understanding that continued services may not be available if an unpaid balance accrues.

All Information Must Be Completely Filled In Below:

Visa MasterCard Discover American Express

Credit Card Holder's Name: _____ Expiration Date: _____
(Please Print)

Credit Card #_____

Billing Zip Code: _____ CVV# (on back of card): _____

Please fill out the information below for any other person(s) you authorize this credit card for: If NO OTHERS ALLOWED, strike through and initial.

Patient Full Name: _____ DOB: ____/____/____
Patient Full Name: _____ DOB: ____/____/____
Patient Full Name: _____ DOB: ____/____/____

Credit Card Holder's Signature: _____ Date: _____