

**Payment Arrangement Agreement**

At Eastover Psychological & Psychiatric Group, P.A., we offer keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn’t cover, but for which you are liable.

Your credit card information is kept confidential and secure. Payments to your card are processed only after the claim has been filed and processed by your insurance company.

**I authorize Eastover Psychological & Psychiatric Group, P.A. to charge the portion of my bill that is my financial responsibility to the following credit or debit card:**

**\_\_\_ Visa \_\_\_ MasterCard**

**Credit Card Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Expiration Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

**CVV Security Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cardholders Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Billing Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City \_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_\_\_**

This authorization will remain in effect until I cancel this authorization.

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Account Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**