MD TruCare
Psychiatry, Endocrinology and Sleep Medicine

823 Ira E Woods Ave. Suite #200
Grapevine, Texas 76051
Ph: 817-722-6078 Fax: 817-722-6077

Financial Card Policy and Consent

I, _____

(Print Name Above)

authorize MD TruCare to keep my credit card/debit card indicated below on file & to be drafted automatically for my co-pay/amount owed for the appointment scheduled. The amount will be charged the morning of the scheduled appointment. I understand this signed consent constitutes as the ONLY notice of payment withdrawal from my account. I am signing this agreement knowing that I will not be given advance notice before the payment is charged. Only the amount for that day's current appointment will be automatically charged, not previous balances on the account. I understand that I will be contacted separately to set-up payments for previous balances, if any occur on my account.

Credit Card Holders Name (As shown on card): _____

Card Number: _____

Billing Zip Code: _____

Expiration Date on card: _____/_____/_____

CVV (Security Code on Card): _____

Card Holder's Signature: _____ Date: _____/_____/_____

Card Holder's relation to patient: _____

Patient Signature : _____ Date : _____/_____/_____

Patients Gardians Signature : _____ Date : _____/_____/_____