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

I,_____Date of Birth __/___/_____

(Patient Name)

hereby authorize MD TruCare to retain my credit card/debit card details (as indicated below on file) to charge for the following purposes- Co-payments or any outstanding balances related to scheduled appointments, and any clinic fees associated with my care, including but not limited to no-show fees, BOA payment plan amounts, and UA (Urine Analysis) fees.

I fully comprehend and acknowledge that this signed consent constitutes the sole notice for the withdrawal of payment from my account. I am aware that advance notice may not be provided before payment is charged. In the event of a declined payment, I understand and accept that a fee of $15 will be incurred. It is my responsibility to ensure that the card information on file with MD TruCare remains accurate and up-to-date.

Credit Card Information:

Credit Card Holder's Name (As shown on card): _____ HSA/FLEX card: ____

Holder's Relationship to Patient: self _____

Card Number: _____

Billing Zip Code: _____

Expiration Date on Card: ____/_____/_____

CVV (Security Code on Card): _____

Patient Signature: _____ Date: ___/___/

Patients/Guardians Signature (If applicable): _____Date: ____/_____/____

Staff Only:

Start Date: _____ End Date: _____ Entered in ECW: _____ Scanned in ECW: _____