156 S. State Street Dover, DE 19904
769 E Masten Circle Milford, DE 19963
118 Sandhill Drive, Suite 200 Middletown, DE 19709
900 Foulk Road, Suite 200 Wilmington Delaware 19803
Phone: 302-674-2380 Fax: 302-674-1299

Patient/Client Name: _____ Date of Birth: _____

This agreement will pertain to the above-named individual(s) and all payments will be posted to only the accounts of the person(s) listed above.

Credit Card#: _____ - _____ - _____ - _____

3-digit code: _____ Expiration Date: _____ Zip Code for Card: _____

_____ (authorized name holder) agree that The Mind and Body Consortium may debit my account in the amount of (complete area below):

$_____ up to $_____ (list fixed amount here.) If the amount due is less than the amount listed, only the balance due will be debited.

_____ for my copayment, co-insurance, deductible amount, and or account balances, I understand that this amount may not be a fixed amount.

In the following manner (initial one):

_____ this will be a one-time payment to be charged on _____ (date)

_____ this will be a recurring charge to be debited on the _____ day of each month until my account balance is zero dollars.

_____ this will be a recurring charge that will be debited each time the above-named client(s) receive services from the Mind and Body Consortium.

Please note:

At any time, you may change your form of payment placed on your account. If you request a temporary date change or permanent date change please send a written notification that the authorization has been terminated. If you do not receive confirmation of the notice the agreement is still in place. We request 48 hours to cancel any pending payments. If your credit card payment is declined, services will be suspended until your balance is cleared.

Authorized Signature: _____ Date: _____

Printed Name: _____

Staff Witness: _____ Date: _____