Pittsboro Pediatric Psychology and ADHD Clinic
290 East St, Ste 106
Pittsboro NC 27312-9448
919-548-5612

5. Credit / Debit Card Payment Consent (PPP+ADHD))

Patient name:

(Card holder) Name on card if different than patient:

Card Type:

Last 4 digits of card number:

Expiration Date :

I authorize Pittsboro Pediatric Psychology and ADHD Clinic to charge my credit/debit/HSA/flex card for professional services at the time services are rendered or when notice of insurance coverage and patient responsibility (EOB) is received. If I do not show up for an appointment and did not provide the practice at least 24 hours' notice, I recognize that Pittsboro Pediatric Psychology and ADHD Clinic will charge my card the appropriate No Show/Missed Appointment fee according to the current Fee Schedule (available on the practice website).

I verify that my credit card information, provided in full in the payment section of the client portal and abbreviated above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred. I also understand by signing and initialing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

Client Initials:

Card holder Initials (If different than client):

Date:

Type name of cardholder here to agree.: