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2025 Payment Policies & Credit Card Pre-Authorization
PLEASE READ THIS DOCUMENT CAREFULLY

If applicable, the patient/ legal guardian does authorize and request that the insurance company/ companies with whom Mosaic Psychiatric Care, LLC is contracted, pay benefits directly to Mosaic Psychiatric Care, LLC for services rendered. The patient/ legal guardian authorizes the release of medical records or other information required by the insurance company/ companies or their designated review agents who provide insurance benefits, needed to determine said benefits, process claims, & secure payment of benefits. The patient/ legal guardian understands that payment is due at the time services are rendered, and if the insurer refuses to cover charges for services provided, the patient/ legal guardian is responsible for and agrees to pay for said charges, including but not limited to cost sharing (copays, deductibles, co insurance, etc), claims denied, or services not covered by the insurance company. Any questions or disputes concerning insurance coverage or payment of benefits are a matter between the policy holder and the insurer.

Credit Card Pre-Authorization Form

Name as shown on credit card: _____ Cardholder's DOB: _____

Address on file with credit card company: _____ City, State & Zip: _____

The Patient/Cardholder/Undersigned Individual hereby authorizes MOSAIC PSYCHIATRIC CARE, LLC to obtain payment of fees for services from the Patient/Cardholder/ Undersigned Individual's Credit Card account identified below.

MOSAIC PSYCHIATRIC CARE, LLC may charge the account

-To secure the patient's appointment time ($75)

-For any missed/late cancelled appointments ($75; minimum of 48 hours cancellation notice is required)

-For self pay or sliding scale appointment fees

-For copays, deductibles, co-insurance, other 'cost sharing' deemed 'patient responsibility' by the insurance company;

-For claims denied, or services not covered by the patient's insurance company

The Patient/Cardholder/Undersigned Individual hereby authorizes MOSAIC PSYCHIATRIC CARE, LLC ***to charge the account, without requirement of the Patient/Cardholder/Undersigned***

Individual's signature for each payment. A receipt for each transaction may be sent to the Patient/Cardholder via email, directly from the Stripe account for Mosaic Psychiatric Care, LLC.

☐ I authorize any balance to automatically be charged to this credit card

Name on credit card: _____

Credit Card #: _____

PLEASE MARK ONE:

○ Visa ○ Mastercard ○ American Express ○ Discover

CVV Number: (3 digits on back of card – AMEX (4 digits on front) _____

Expiration Date: (Month/Year) _____

By signing this form, the Patient/Cardholder/Undersigned Individual acknowledges and agrees as follows:

- This signed form is confidential and will be maintained on file with MOSAIC PSYCHIATRIC CARE, LLC.
- The Patient/Cardholder/Undersigned Individual authorizes MOSAIC PSYCHIATRIC CARE, LLC to automatically charge the above-referenced Credit Card.
- The Patient/Cardholder/Undersigned Individual certifies, warrants and represents that the Cardholder named above agrees to pay the credit charge(s) in accordance with the agreement described above.
- Credit Card payments will appear on your statement as MOSAIC PSYCHIATRIC CAR (for MOSAIC PSYCHIATRIC CARE, LLC).
- If the Patient/Cardholder/Undersigned Individual fails to dispute a charge within 30 days from the time the Credit Card is charged, the Patient/Cardholder/Undersigned Individual agrees that the charges are valid and agrees not to dispute said charges.
- This authorization will remain valid until revoked in writing, with 30 days notice of revocation.

I certify that I have read and understand the entirety of this document, titled “2025 Payment Policies & Credit Card Pre-Authorization." By signing below, I am agreeing with this document, put forward by MOSAIC PSYCHIATRIC CARE, LLC.

Name of Authorized Signer: _____

_____ _____

Patient/Cardholder Authorized Signature Date