mind matters, P.C.
CHILD & FAMILY PSYCHIATRY
Healing Minds, Changing Lives

AUTOMATIC BILLING AUTHORIZATION FORM

Patient Name:____________________________________ Patient ID: ____________________
(*for office use only*)

Other family members seen at MMPC:____

I authorize Mind Matters, PC to charge my credit card listed below for:

___ co-pays at the time of service

___ my balance after my insurance has processed the claim

Credit Card Account Information

VISA ___ Mastercard ___ Discover____

____
Name on credit card (exactly as printed)

____
Billing address for credit card (Street, Apt.#)

____
City, State, Zip

____
Credit card number Expiration date

____
Signature Today's date

18650 NW Cornell Road, Suite 315, Hillsboro, Oregon 97124 – tel: (503) 352-0468 – fax: (503) 352-1024