

Nashville
MENTAL HEALTH PARTNERS
HEALING AND HOPE FOR ADULTS

Billing Information Form

Thank you for providing the below information to our practice. This information will be utilized to collect payment in the event of a no show, a late cancellation or at the end of your appointment. Per our policy, appointments require a 24-hour cancellation outside of emergencies and all no shows will be charged the full amount for the missed appointment. **Your signature below grants PsychMed Solutions, PLLC permission to charge your credit card for the full amount of the missed appointment.** We appreciate your understanding and cooperation and thank you for the opportunity to be a part of your care.

– Mimi and Kristian

Name: _____

Credit Card Information:

Name on Card: _____

Billing Address, including zip code: _____

Card Number: _____

Security Code: _____

Expiration Date: _____

Signature: _____