4414 Westlawn Drive

Nashville, TN. 37209

Office: 615-900-4442

Fax: 615-349-1820

**Payment Agreement Form**

To Be Completed for Administrative and Billing Purposes:

(All requested information is REQUIRED to receive further care and/or appointments)

Person Responsible for Payment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number (Preferably Cell Phone): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail of Person Responsible for Payment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number of Person Responsible for Payment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*Social Security Number will only be used if referral to collections becomes necessary*

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize medical treatment by The Tennessee TMS Center, and agree to assume full responsibility of any fees associated with my TMS treatment.

Fees include 30 treatment sessions to be administered in a 6 week period\*. TMS Therapy is a commitment of both you, the patient, and The Tennessee TMS Center staff therefore we expect patients to attend all appointments and provide 24 hour notice if there is need to reschedule.

After discussing payment options I have decided to pay: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Should it become necessary, I authorize The Tennessee TMS Center to release and exchange in verbal and/or written form any information necessary for the payment of fees, and/or the provision of my medical care. This may include information related to alcohol or substance abuse. In addition, should it become necessary to need the services of a collection service or an attorney to secure payment, I am aware that I will be responsible for all costs, attorney fees, and other related expenses to the collection effort.

Payment may be in the form of cash, check\*\*, or credit card. We accept Visa, MasterCard, and Discover credit cards. There is a 3% charge fee when using a credit card for payments. I am aware that failure to pay in the form I have chosen and as agreed upon in my payment plan will result in the credit card on file being charged the appropriate amount on the day of the scheduled payment. I am also aware that the signature below authorizes The Tennessee TMS Center to keep my credit card and signature on file and to use this credit card for the above mentioned charges, I am aware that this form is valid and I authorize these charges.

Credit Card Type (please Circle):

Visa

MasterCard

Discover Card

Card Holder's Name (As it appears on card): \_

Card Holder's Address: \_

*Street City State ZIP*

Credit Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3 Digit CVA# on Back of Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Card Expiration Date: \_\_\_\_\_ / \_\_\_\_\_\_

Signature of Card Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have read this form completely and agree to the conditions set forth in this form.

Signature: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\* note some patients may choose to save a few treatments for a later date to use as boosters, this will be discussed and decided upon between Dr. Barton, your TMS Coordinator, and the patient towards the end of treatment. All 30 treatments must be paid up front and in full, the remaining monies from initial treatment put towards booster treatments expire 1 year after the initial treatment start date*

*\*\*if patients choose to pay with cash or check payment must be made in full or patient must provide a credit card for our files which may be charged if cash payment isn’t made by the specified date or if checks are returned.*