CONSENT FOR TELEMEDICINE SERVICES

I hereby consent to telemedicine counseling sessions with my Meier Clinics counselor.

If the counselor I am seeing is an approved provider through my insurance company, Meier Clinics will contact them to see if telemedicine is covered and has advised me to do likewise. I understand, however, that a quote of benefits is not a guarantee of payment and agree to pay for all charges in full for telemedicine services not covered by my insurance.

I agree to pay for telemedicine services at the time of service via credit card. By completing the form below, I authorize Meier clinics to process payment for telemedicine services at the time of service, as well as any balance due for previous telemedicine services provided which my insurance refuses to cover.

_____
Patient Name (please print)

_____ _____
Patient Signature Date

CREDIT CARD AUTHORIZATION

I authorize Meier Clinics® to keep my signature on file and to charge my credit card on the date of service for Telemedicine sessions provided.

Card Holder Name: _____
(EXACTLY AS IT APPEARS ON CREDIT CARD)

Mailing Address: _____

City, State, Zip _____

Card Number: _____ CVV Code: _____
(Amts. over $50)

Expiration Date: _____ /_____

Check One: MasterCard ❑ Visa ❑ American Express ❑ Discover ❑

This agreement for payment shall not exceed $_____ . _____ per session.

Card Holder Signature: _____ Date: _____