Butler Psychiatric Services, LLC
William Butler, M.D.
E: Admin@ButlerPsychitricServices.com
T: 617-468-6443

Credit Card Authorization Form
Butler Psychiatric Services, LLC

Please review the following policies regarding payment and credit card authorization. By signing this form, you acknowledge and agree to the terms below.

1. Payment at Time of Service
All services must be paid for in full at the time of service, as outlined in the practice's financial policies. Additional services cannot be rendered without payment.

2. Autopay Enrollment (Optional)
You may choose to enroll in monthly autopay for convenience. By selecting this option, you authorize Butler Psychiatric Services, LLC, to charge your credit/debit card on a recurring monthly basis for services rendered.

- **Amount Billed**: Charges will reflect services rendered in the prior month, based on the practice's current fee schedule.
- **Billing Date**: Autopay will be processed on the first of each month, or on another agreed-upon date.
- **Scope**: The total amount charged may include any unpaid balance from previous sessions.

If you wish to enroll, your credit card information will be collected securely via phone.

3. No Carrying a Balance
All payments must be settled in full at the time of each session. Clients may not carry a balance. If enrolled in autopay, your card will be charged monthly for all sessions completed in the prior month.

4. Canceling Autopay
You may cancel autopay at any time by providing written notice at least seven (7) business days before the next scheduled charge. Once canceled, payment will be due at the time of each session.

5. Refund Policy
Refunds will not be issued for completed services. If an overpayment is made or a session is canceled in accordance with practice policy, a refund or credit will be issued for any unused portion.

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6. Payment Processing Notice
Online payments are processed via Stripe, a third-party vendor that does not sign a HIPAA Business Associate Agreement (BAA). No protected health information (PHI) is shared with Stripe. By choosing to pay electronically, you acknowledge and accept this payment method.

If you prefer, you may pay by **cash or check** at the time of service.

7. Public Insurance Acknowledgment
No Billing or Reimbursement Through Public Insurance Programs
This practice is out-of-network for all insurance plans and does not bill any insurer on your behalf. If you are enrolled in Medicare, Medicaid, or MassHealth, you acknowledge that:

- You are seeking services voluntarily and understand that these services are not covered or reimbursable by those programs.
- You will not submit claims to Medicare, Medicaid, or MassHealth for reimbursement.
- The practice does not provide superbills or documentation to support claims to these programs.
- You accept full financial responsibility for all charges incurred.

Dr. Butler is not able to provide services to Medicare beneficiaries through his private practice. If you are covered by Medicare (including as a secondary insurer), you must inform Dr. Butler immediately so that appropriate referrals can be made to support your continuity of care.

Optional: Autopay Enrollment
If you would like to enroll in monthly autopay, please enter your credit card information below.

Autopay Enrollment

Please indicate whether you wish to enroll in autopay below.

☐ Yes, I wish to enroll in monthly autopay.
By checking this box, I authorize Butler Psychiatric Services, LLC, to charge my credit/debit card on a recurring monthly basis for services rendered in the prior month. I understand the amount charged will reflect services rendered in the previous month, based on the practice's

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fee schedule.

☐ No, I do not wish to enroll in monthly autopay.

I hereby authorize Dr. William Butler to charge the credit or debit card provided below for all services rendered, including psychiatric assessments, diagnosis, and treatment, at the conclusion of each clinical visit.

I understand and agree that payments are due at the time of service, and that **autopay may be used** to process charges for monthly services based on the previous month's treatments. I also acknowledge that I am responsible for ensuring that payment is made for each session, and that a balance cannot be carried from one session to the next.

Should I wish to revoke this authorization at any time, I understand that I must notify the office in writing or by phone at least **7 business days before the next scheduled payment date**. This authorization will remain in effect until the conclusion of treatment or until I revoke it, whichever occurs first.

Receipts and superbills can be provided upon request.

By signing this form, you confirm your understanding and agreement to these terms.

_____
Name (Print)

_____
Signature

_____
Date

Please return this document to William Butler, M.D., via fax or email before your initial appointment.