



Credit Card Authorization Agreement

I, _____, am the holder of

Visa____, MasterCard____, Discover____ (check one please)

Cardholder name: _____ Card number: _____

Expiration date: _____/_____/_____ CVV# (on back of card): _____ Card Holder's Zip Code _____

I authorize the Psychiatric Wellness Center to charge my credit card. **Initial** _____

I understand and agree that the Psychiatric Wellness Center will charge my credit card \$100.00 fee if I do not cancel any appointment within 1 business day, if I am late for my scheduled session or if I do not show for my scheduled session. **Initial** _____

I understand and agree that the Psychiatric Wellness Center will charge my credit card for any outstanding balance past 30 days from date on my invoice. **Initial** _____

I understand that if the above card information is incorrect or is denied I will be charged a \$50 fee due immediately. **Initial** _____

I understand my insurance will not pay for late cancels, missed appointments or fees and I will be responsible for payment. **Initial** _____

I understand that if I refuse to leave a valid card on file I must pay all balances within 30 days or I will be discharged from the Psychiatric Wellness Center and I will no longer receive treatment including: medication management and/or psychotherapy. I also understand that all no show fees are due the same day or I can not schedule a new appointment and any current appointments will be cancelled until the fee is paid. **Initial** _____

I hereby authorize the Psychiatric Wellness Center to process my credit card with their merchant services. I understand that the Psychiatric Wellness Center is not responsible for any security or liability issues with merchant services.. **Initial** _____

I have read this entire agreement and understand that I will be held fully responsible for its terms and charges and I agree that all charges are final and that there are no refunds for services rendered.

Patient Name (Print) _____

Patient/Parent/Legal Guardian Signature _____ Date _____

Witness Signature: _____ Date: _____