Credit Card on File: Billing Authorization Form

Please note, the card provided must be a CREDIT CARD, not a debit card, to avoid problems related to non-sufficient funds transactions.

I understand

The undersigned agrees and authorizes House Psychiatric Clinic to charge the credit card indicated below for any account balances.

I understand

Account balances include, but are not limited to, co-pays, coinsurance, fees for late cancellations and no-show appointments.

I understand

Client's name:

Name as it appears on the credit card:

Type of credit card:

Visa

American Express

Mastercard

Discover

Card number:

Expiration date:

Security code:

By typing your name below, you are agreeing to the following statement:

I authorize House Psychiatric Clinic to process the above credit card as "Signature on File" for any balance due on my account.

I understand this authorization will expire upon written notice

I understand

Please type your full name:

Today's date: