House Psychiatric Clinic

Billing Authorization Form

Please note, the card provided must be a credit or 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/debit card: ________________________________

Type of card:

○ Visa

○ American Express

○ Mastercard

○ Discover

Card number: ______ - ______ - ______ - ______

Expiration date: ____/____

Security code: ________

By signing 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.

Signature: ________________________________