CREDIT CARD AUTHORIZATION FORM

Our office requires that a credit card be kept on file for payment of any co-payment, co-insurance, deductible, or charge that may not be covered by your health insurance. This form will be kept confidential and only authorized staff has access to the information.

PATIENT'S NAME: _____

NAME, AS IT APPEARS ON CREDIT CARD: _____

BILLING ADDRESS: _____

_____

EMAIL ADDRESS: _____

AMEX/DISC/MC/VISA CARD # _____

EXPIRATION DATE: _____/_____ **VERIFICATION CODE (3 or 4 DIGITS)** _____

PLEASE PROVIDE THE CARDHOLDER'S DRIVER'S LICENSE

I acknowledge and authorize SoCal Therapy Center to charge the above credit card account for any co-payment, co-insurance, deductible and/or charges not covered by my health insurance provider. I acknowledge that my card will be run in the event payment is not received within thirty days after I receive a statement. I agree to receive billing statements, invoices and receipts via the email I have provided to this office. If I am an uninsured patient I authorize payment at time of service. I agree to update any information regarding this credit card account.

_____ _____

Cardholder Signature Date