ARBOR PSYCHIATRIC AND WELLNESS CENTER

CREDIT CARD AUTHORIZATION FORM

In adherence to our clinic policy, we ask each patient to keep a credit card authorization form on file in the event that you cannot or do not pay fees that are outstanding, remain as part of your visit, or as it pertains to any no show fees. This form will be kept confidential and only authorized staff will have access to this information.

Your signature below indicates your agreement and consent to charge your credit card for any outstanding charges for any service fees which may include no shows, phone services, and other fees as outlined in clinic policies and procedures.

I, _____ (*name as it appears on the credit card*), authorize Arbor Psychiatric and Wellness Center to submit any charges for professional services that are rendered to _____ (*full legal name of patient*) to my credit card. This authorization applies to all legitimate charges for any individual whom I have accepted financial responsibility and includes all current and future outstanding charges.

I understand that Arbor Psychiatric and Wellness Center reserves the right to charge the credit card listed below for all current or past due balances, including co-pays, co-insurances, deductibles, and no-show fees. If charges or balance exceeds $50, Arbor Psychiatric and Wellness Center will charge the credit card listed below $50/month until the balance is paid off or if other payment terms have been agreed upon. This notice serves as your consent to being charged for all current and past due patient balances on your account.

I understand that I can request a receipt for charges and updated statements at any time by phone, email, or mail. This authorization will not expire and can be withdrawn in writing at any time.

Name on Credit Card: _____

Type of Credit Card: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Credit Card Number: _____ - _____ - _____ - _____

Expiration Date: _____/_____ Card Verification Data: _____ (3 digits on back)

Zip Code applicable to Credit Card: _____

Full legal name of patient authorized for use:_____

Signature of Cardholder: _____

Date: _____ Staff Initials: _____

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