Comprehensive Psychiatric Associates

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Mental Health Services for
Children, Adolescents, Adults, and Families

www.WellPsych.com

Credit Card Authorization

We ask to keep a credit card authorization on file for every client. In the event that you cannot or do not pay whatever fees are your responsibility at the time of your visit, we will submit the charge to your credit card. Your signature below indicates your agreement and consent to this process. Your card will be charged only if you do not pay at the time of your visit, or if there are outstanding charges for deductibles, co-payments, missed appointments, late cancellations, or service charges. You will be notified in writing any time we have made a charge to your credit card.

I, _____ , authorize
(please print name as it appears on your credit card)

Comprehensive Psychiatric Associates to submit charges for professional services

provided for _____
(name of client)

to my credit card. This authorization will be in effect until I notify Comprehensive Psychiatric Associates in writing to discontinue this authorization. This authorization applies to all legitimate charges applicable for any individual for whom I have accepted financial responsibility, and includes all currently outstanding charges and future charges.

_____
Card Type
(Visa, MasterCard, Amer Exp, Discover)

Card Number

_____
Expiration Date

_____
Name of Card Holder, Printed

_____
Signature of Card Holder

_____
Date of Signature