CREDIT CARD AUTHORIZATION FORM

Irving &
Associates in
Behavioral Health, P.C.

Date:
_____/_____/_____

Filed by:

ACCT#_____

Client's LEGAL Name: _____

Name on Card: _____

Client's Relationship to Cardholder: _____

**We accept Visa, MasterCard, & Discover **

Credit Card Number: _____-_____-_____-_____

Credit Card Expiration Date: _____/_____

Credit Card Security Code (three digit code found on the back of the card): _____

Billing Zip Code: _____

Payment Plan/Arrangements (if applicable):

- I agree to have the above credit card on file and processed for my portion of all payments not covered by my insurance company. I understand my card will be processed after my insurance has paid their portion or the rate agreed upon at the time of service. **I also understand this card will be charged for LATE CANCEL FEES OF $50.00 and NO SHOW FEES OF $100.00.**

Your signature indicates you understand these fees, and you know they are non-refundable.

Upon the termination of services, I understand that the above credit card will be charged the balance owed. I also understand if my card is declined and I have not made any payments towards my balance in 120 days OR have not made payment arrangements, my account is considered inactive and may be sent to a credit collections agency.

Print Name: _____

Signature: _____