Credit Card on File

First Name _____ Last Name _____ M.I. ____ Date of Birth _____

I authorize Conventions Psychiatry and Counseling to keep the following credit card(s) information on file.

Primary Card Account

Name on credit card (Exactly as printed) _____

Billing Address _____

Credit Card Number _____

Exp. Date _____ CVV2# _____

Signature _____ Date _____

Secondary Card Account

Name on credit card (Exactly as printed) _____

Billing Address _____

Credit Card Number _____

Exp. Date _____ CVV2# _____

Signature _____ Date _____

I authorize Conventions Psychiatry and Counseling to charge my credit card on file for balances indicated below:

Co-payments
Coinsurance
Deductible
Office Fees- Not limited to: no-show fee, cancellation fee, prescription fee, etc.

Since the payment amount may vary, I will be notified of the amount and date of the transaction. This authorization is valid until I provide you with written cancellation.

Patient/Legal Guardian Signature _____ Date _____