CREDIT CARD ON FILE POLICY

At Family Psychiatry Practice & Associates you may keep your credit or debit card on file as a convenient method of payment for all services provided. Your card information is kept confidential and secure. Charges to your card are processed only after services are rendered.

Cardholder Name: ____

Cardholder Phone Number: ____

Cardholder Address: ____

City ______________________________________State___________Zip ______________

Last Four Digits of Card on File: ____________

Cardholder Signature: _______________________________________Date:____________________

I, the undersigned, authorize Family Psychiatry Practice & Associates to charge my credit or debit card, indicated above, for balances due for services rendered at the time of service. I understand that charges for appointment no-shows and late cancellations may be placed on this card. This authorization relates to all payments for services provided to me by Family Psychiatry Practice & Associates.

This authorization will remain in effect until I cancel this authorization in writing. To cancel I understand the account must be in good standing.

Patient Name: ____DOB: ________________

Patient/Guardian Signature: ____________________________________Date:____________________

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