CREDIT CARD AUTHORIZATION FORM

We ask that you fill out this credit card authorization form, which will be kept in your file. You may pay for your sessions including co-payments, deductibles or any amount that is not covered by your insurance via cash, credit card, flexible health spending plans, money order, or PayPal. Our office does not accept personal checks. Due to the billing system used, your credit card will be charged automatically for sessions that are cancelled with less than 24-hours notice, missed sessions, and any amount that is not paid within 15 days of receiving an invoice. We will attempt to contact you at the time these charges are submitted as a courtesy. The charges will show up on your statement as "Providence Residential & Outpatient PTSD Services-PROPS."

I authorize Providence Residential & Outpatient PTSD Services-PROPS to keep the information for my credit or debit card on file for payment and also to initiate applicable payment entries as balances are owed on my account. I understand and agree that these entries may be made to my debit or credit card, as applicable. I also agree to inform Providence Residential & Outpatient PTSD Services-PROPS if my debit or credit card information changes for any circumstance. This authorization will remain in effect until the conclusion of my services with Providence Residential & Outpatient PTSD Services-PROPS, the expiration date of my credit card, or until I communicate to Providence Residential & Outpatient PTSD Services-PROPS my intention to terminate services by calling 770-577-7873 or writing to Providence Residential & Outpatient PTSD Services-PROPS at the address: 6576 Church Street, Douglasville, Georgia 30134.

I acknowledge receipt of a copy of this authorization form

Name on Credit Card: _____

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

_____

Card Number : ☐☐☐☐-☐☐☐☐-☐☐☐☐-☐☐☐☐

Expiration Date: ☐☐/☐☐☐☐

Card Verification Data:_____ (3 digits on back of credit card for most; American Express may be in front of card)

Zip Code applicable to Credit Card: _____

Full legal name of patient authorized for use: _____

Signature of Cardholder: _____ Date: _____

Printed name:_____