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 via cash, credit card, flexible health spending plans, money order, PayPal (additional 2% required as of 8/1/21), or Zelle. Our office does not accept personal checks. Due to the billing system used, your credit card will be charged automatically after you have applied your 1 waiver for missed appointments per year for sessions that are canceled 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 "Felicia Berry-Mitchell."

I authorize Dr. Felicia Berry-Mitchell, LLC/Dr. Felicia Berry-Mitchell 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 Dr. Felicia Berry-Mitchell, LLC/Dr. Felicia Berry-Mitchell if my debit or credit card information changes for any circumstance. This authorization will remain in effect until the conclusion of my services with Dr. Felicia Berry-Mitchell, LLC/Dr. Felicia Berry-Mitchell, the expiration date of my credit card, or until I communicate to Dr. Felicia Berry-Mitchell, LLC/Dr. Felicia Berry-Mitchell my intention to terminate services by writing to Dr. Felicia Berry-Mitchell, LLC/Dr. Felicia Berry-Mitchell at the address: PO Box 5464, Douglasville, Georgia 30154.

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; 4 digits 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:_____