Credit Card Authorization Agreement

I _____, authorize Alpha Psychiatric Services to use my credit card information to charge my credit card for co-payments, outstanding balances, and in the event that I do not notify the office of my inability to attend scheduled appointments and/or do not cancel my appointment at least 24 hours in advance. The set cancellation fee is $50 unless otherwise agreed upon with my provider. I will not dispute charges ("Charge Back") for sessions I have received or commitments I have missed according to the above policy.

Card Type (circle one):

VISA MasterCard Discover American Express

Credit Card #: _____ Expiration Date:_____

Name as Printed on Card: _____

Verification/Security Code (3-digit code on back of card by signature line): _____

*I would rather add my credit card information to the electronic vault: Yes: ☐ No: ☐

Billing Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email Address: _____

By signing below, I am authorizing Alpha Psychiatric Services to charge for missed scheduled appointments with email confirmation and receipt.

Signature: _____ Date: _____

Credit Card Authorization Agreement DENIAL

I DO NOT feel comfortable sharing my credit card information with Alpha Psychiatric Services to be stored in their secure Electronic Health Record for the purpose of billing. I agree to receive paper and/or electronic statements for any charges that may be outstanding on my account. I agree to pay any unresolved balances once notified or make appropriate payment arrangements with their billing staff. Any balance that remains unresolved beyond 30 days is subject to past due penalties.

Signature: _____ Date: _____