Credit Card
Pre-Authorization Form

Patient Name: _____

Patient Address: _____

_____

The undersigned Patient/Cardholder hereby authorizes Bearden Behavioral Health, to obtain payment of fees for services from the Patient/Cardholder's Credit Card account identified below. Bearden Behavioral Health may charge the account for missed appointments *(minimum of 24 hours cancellation notice is required),* without requirement of the Patient/Cardholder's signature for each payment. A receipt of the transaction will be mailed to the address provided by the Patient/Cardholder above. **The Patient/Cardholder may also choose to have any remaining balances owed billed to this credit card by selecting the appropriate option below.**

□ **I authorize any remaining balance to automatically be charged to this credit card.**

Name on credit card: _____

Credit Card #: _____

PLEASE CIRCLE ONE: Visa MasterCard American Express Discover

CVV Number: (3 digits on back of card – AMEX (4 digits on front) _____

Expiration Date: (Month/Year) _____

Patient/Cardholder Authorized Signature: _____

Printed Name of Authorized Signor: _____

By signing this form, the Patient/Cardholder acknowledges and agrees as follows:

- *This signed form is confidential and will be kept on file at Bearden Behavioral Health.*
- *The Patient/Cardholder authorizes Bearden Behavioral Health to automatically charge the above-referenced Credit Card.*
- *The Patient/Cardholder certifies, warrants and represents that the Cardholder named above agrees to pay the credit charge(s) in accordance with the agreement described above.*
- *Credit Card payments will appear on your statement as Bearden Behavioral Health.*
- *If the Patient/Cardholder fails to dispute a charge within 30 days from the time the Credit Card is charged, the Patient/Cardholder agrees that the charges are valid and agrees not to dispute said charges.*
- *This authorization will remain valid for 12 months or until revoked in writing with 30 days notice of revocation.*