CREDIT CARD
PRE-AUTHORIZATION FORM

Patient Name: _____ DOB: _____

Address: _____
Street

_____ _____ _____
City State Zip

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.

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 below-referenced Credit Card any remaining balance on the above-named patient's account (including copays, co-insurances, deductibles or missed appointment fees).
- 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 and will automatically renew on an annual basis, unless revoked in writing with 30 day notice of revocation.
- This authorization serves as agreement for receipts to be noted "signature on file" when charged.

PLEASE CHECK ONE: ☐ **Visa** ☐ **MasterCard** ☐ **Discover**

Name on Card: _____

Credit Card #: _____

CVV # (3 digits on back of card: _____

Expiration Date (Month/Year): _____

Printed Name of Authorized Signer: _____

Patient/Cardholder Authorized Signature: _____