TELETHERAPY
CREDIT CARD AUTHORIZATION FORM

Patient Name: _____ DOB: _____

Address: _____
Street

_____ ____ _____
City State Zip

The undersigned Cardholder hereby authorizes Bearden Behavioral Health, to obtain payment of fees for services from the 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 Cardholder's signature for each payment. A receipt of the transaction will be mailed to the address provided by the Cardholder above.

The Cardholder may also choose to have any remaining balances owed billed to this card by selecting the appropriate option below.

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

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 Cardholder authorizes Bearden Behavioral Health to automatically charge the Credit Card referenced below.
- The 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 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.
- Credit Card will be charged for telepsych services within one hour of scheduled appointment time.

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: _____

Cardholder Authorized Signature: _____