BOSC MENTAL HEALTH

Credit Card Authorization Form

Client Information

Full Name: _____
Date of Birth: _____
Address: _____
City: _____
State: _____
Zip Code: _____

Credit Card Information

Credit Card Type: ☐Visa ☐MasterCard ☐Discover ☐American Express

Cardholder Name (as it appears on card):_____
Credit Card Number: _____
Expiration Date: _____
CVV/3 digit security code: _____
Billing zip code: _____

I, the undersigned, authorize BOSC MENTAL HEALTH (hereinafter referred to as "the Practice") to charge the above credit card for the following services:

1. Payment for psychiatric services rendered, including but not limited to office visits, telehealth appointments, consultations, assessments, and any other charges applicable as agreed upon by the Practice and myself.
2. Payment for any outstanding balances or co-pays not covered by my insurance or other forms of payment.
3. Any future charges for services I receive during my course of treatment.

I understand and agree to the following conditions:

1. **Ongoing Authorization**: This authorization will remain in effect until I notify the Practice in writing to revoke it. I understand that I am responsible for updating my card information with the Practice if any changes occur (e.g., expiration date, account number, billing address).
2. **Notice of Changes**: I agree to notify the Practice immediately if my credit card information changes or becomes invalid, and I understand that if the Practice cannot process payment due to invalid or outdated information, I may be subject to cancellation of appointments or other penalties.
3. **Payment Processing**: I acknowledge that my credit card will be charged automatically for services provided by the Practice, and I agree to pay for any amounts owed according to the terms outlined in the Practice's billing policies.
4. **Privacy and Security**: I understand that the Practice takes reasonable precautions to ensure the security of my credit card information and complies with all applicable laws regarding data protection.

Client's Signature

By signing below, I acknowledge and agree to the terms and conditions outlined in this Credit Card Authorization Form. I also confirm that the information I have provided is accurate.

Signature: _____
Date: _____
Printed Name: _____
Relationship to Client (if applicable): _____

Practice Use Only
Processed by: _____
Date: _____

Please retain a copy of this form for your records.