South Coast PSYCHIATRY
Psychotherapy & Medication Management

CREDIT CARD AUTHORIZATION

Please complete the following information.

I,_____ , am authorizing South Coast Psychiatry, Inc. to charge
(print name)
my credit card for any services rendered as agreed to in the Treatment Consent Form. I also authorize SCP to charge my card in the event I fail to show for a scheduled appointment, or do not give notification of my inability to attend a scheduled appointment at least 48 business hours in advance. Furthermore, for outstanding payments of services rendered, I authorize South Coast Psychiatry to charge my credit card for the full amount due. I will not dispute for sessions I have received, or that I have not canceled less than 48 business hours in advance.

I further authorize South Coast Psychiatry to disclose information about my attendance/cancellation to my credit card company if I dispute a charge.

I acknowledge that I am aware there is a $50.00 fee for any declined credit card charge

Card Type (circle one): Visa MasterCard Discover American Express

Card #:_____ CSC:_____ Expiration Date:_____

Name as Printed on Card:_____

Relationship to patient:_____

Billing Address: _____
(Street, City, State & Zip)

Signature: *(client or financially responsible party)*_____ Date:_____
*Cancellations must be made at least 48 hours in advance or fee must be paid in full and I am aware there is a $50.00 fee for declined credit cards.

This form will be securely stored in your clinical file and may be updated upon request at any time. Please note, your credit card will not be charged unless the following conditions apply: no-show for a scheduled appointment, cancellation less than 48 business hours in advance, or participation in treatment (eg. appointment or phone session) without payment rendered.