SP ASSOCIATES

Credit Card Authorization Form

Name of Patient: _____ Date: _____

Full name on Credit Card: _____

American Express: ◯ Discover: ◯ Master Card: ◯ Visa: ◯

Card Number: _____

Expiration Date on Card: _____ CVV Code: _____

Payee Phone Number: _____

Billing Address on Card: _____

_____

(City) (State) (Zip)

- I give Statesboro Psychiatric Associates permission to charge the above credit card for payments due after each visit, and for any balances to include charges incurred due to appointments missed or canceled without appropriate notice.

Signature of Cardholder: _____ Date: _____

*Digital Signature

- If I have any questions about these charges, I agree to contact Statesboro Psychiatric Associates. I agree that I will not pursue a refund directly through my credit/debit card company, bank or financial institution. If any of my actions yield a charge back fro any reason, I agree to pay any and all penalty fee(s) incurred by Statesboro Psychiatric Associates. I also understand that my card information will be kept secure.

Signature of Cardholder: _____ Date: _____
*Digital Signature