Credit/Debit Card Payment Consent Form

We impose a 3% surcharge for all credit card transactions.

Patient Name: _____

Name on Card, if different: _____

I authorize **The Center for Family Psychiatry** to process a one-time charge to my credit/debit card for professional services as follows: ☐ $475 for Dr. Bhargave or ☐ $400 for Nurse Practitioner (please check the box)

We impose a 3% surcharge for all credit card transactions.

Initial Below:

_____ Initial Intake Appointment Scheduled on _____.

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

Card Number: _____ -- _____ -- _____ -- _____

Expiration Date: ____/_____ **CVV Number:** _____

Card Holder's Billing Address for Statements:

Street: _____

City, State & Zip Code: _____

Phone Number: _____

Card Holder Signature: _____

I _____ (guarantor) on behalf of _____
do hereby authorize **The Center for Family Psychiatry** to charge the above credit card account 48 hours prior to the initial intake appointment for the amount specified. By signing this agreement,

Initial Below

_____ I understand that the full amount for the initial intake appointment will be charged and will then be credited towards my appointment on the above scheduled date.

_____ I understand that a cancellation after the 48 hour window can be rescheduled, but no refunds will be given after that time. If I do not show up for the appointment, it will not be rescheduled and I forfeit the fee in its entirety.

_____ I understand this credit card will not be kept on file unless additional authorization is given on the day of my appointment. This information will be destroyed on the day of my appointment.