Authorization for Credit/Debit Card Payment of Fees

Patient name: _____

Cardholder name: _____

Card Type: ____ Master Card ____ Visa ____ Discover ____ AMEX ____ Other

Credit Card number: _____

Expiration date (mm/yy): _____

Security # on back of card: _____

Cardholder ZIP Code (from credit card billing address): _____

I, _____ authorize payment of fees by my credit card to Inspire Therapeutic Services, LLC for services rendered. I authorize my credit card to be used to resolve any and all balances in full on my account for mental health services, missed or forgotten payments, and/or appointments cancelled or no-shows within 24 hours as per the Agreement for Services statement. I understand that payment is required at the time of service and I may choose to use my credit card on file, cash, check or debit card. I understand that I am required to provide up-to-date account information on file for regular appointment payments, forgotten payments and missed appointments. I also understand that late payments may be subject to an additional late payment fee. Ongoing noncompliance with payment terms may incur collections charges if I do not provide timely payment to resolve my balance.