Finding HOPE

**3545 Ellicott Mills Drive, Suite 310, Ellicott City, Maryland 21043**
**Phone: 443.963.3729 Fax 443.426.4476**

# Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect for one year, or until cancelled or updated in writing.

| **Credit Card Information** |
|---|
| Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX<br>☐ Other _____ |
| Cardholder Name (as shown on card): _____ |
| Card Number: _____ |
| Expiration Date (mm/yy): _____ Security Code: _____ |
| Cardholder ZIP Code (from credit card billing address): _____ |

I,_____, authorize Finding Hope, LLC to charge my credit card above for services at the stated rates(s) according to my insurance coverage and/or customary out-of-pocket fees for services provided to _____.

I agree that my card may be charged for:

- Co-pays, deductibles, co-insurance, and out-of-pocket amounts
- Fees for services that are not covered by insurance
- Appointments missed or cancelled with less than 24 hours' notice

By signing this document, I authorize Finding Hope, LLC to charge my credit card for services provided. I understand that my information will be saved to file for future transactions on my account and that I am responsible for notifying Finding Hope LLC about any changes to my card information. Cards will be charged by the end of the business day on the date that services are rendered. I understand that some of my identifying information may be released during credit card transactions and I consent to this release. I certify that I am the owner of this credit card and am responsible for monitoring my balance. I certify that I will not dispute any charges made to this card as long as the charges meet the terms listed on this form. If applicable, I understand that I am responsible for monitoring my FSA/HSA card and ensuring it has an adequate balance to cover any charges.

_____ _____
Client Signature Date

_____ _____
Signature of Card Holder Date