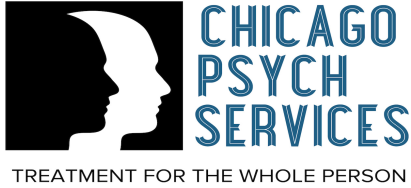

155 North Michigan Ave., Suite 622
Chicago, IL 60601
www.chicagopsychservices.com
312-912-3978

Credit Card Information Form

Prior to receiving services, my office requests that you provide a credit card to have on file. This information will be used to reserve appointments, and ensure payment in the event reimbursement is not made by an insurance company or otherwise, and for missed appointments that I am not notified about within 48 hours. Please fill out the information below.

Credit Card Information

Credit Card Type: ____Visa ____ MasterCard ____ Discover ____ AmEx

Name as it appears on card: ____

Billing address:

____

Street Apt/Unit #

____

City State Zip

Credit Card Number: ____

Expiration Date: ______________ CCV: __________

I hereby authorize Dr. Scott Hoye, Psy.D. to charge my credit card account for fees related to rendered services. These fees include, but are not limited to: copays/co-insurances, deductibles, services not covered by my insurance, and/or self-pay fees, and missed or appointments**. I understand that I will be able to provide payment through the method of my choice on current balances**; however, outstanding balances that are past due 30 days will be charged to the credit card on file, unless other arrangements have been made.

This authorization is valid until I provide Dr. Scott Hoye, Psy.D. with a written notice of cancellation.

______________________________ (Client Signature) ______________ (Date)

______________________________ (Client Print Name)

______________________________ (Witness) ______________________ (Date)