



CREDIT CARD AUTHORIZATION FORM

Patient Name: _____ DOB: _____

Phone: _____ Client Acct #: _____



VISA



AMERICAN EXPRESS

Credit Card Number _____

Expiration Date: _____

CVV Code: _____

Cardholder Name: _____

Billing Address: _____

City

State

Zip Code

Phone Number: (____) _____ - _____

I, _____ (Cardholder), authorize Gulfcoast Behavioral Health to charge my credit card for balances of charges for services rendered that were not paid by or covered by insurance within 90 days, as well as any balance resulting from missing appointments and/or late cancellations.

This agreement shall remain in effect until the Office is notified in writing by the Cardholder to cease all charges.

Cardholder Signature

Date

Witness

