gulfcoast BEHAVIORAL HEALTH
1938 SOULE ROAD, CLEARWATER, FL 33759 Ph. (727) 726-7442 F. (727) 288-1111 www.gulfcoastbh.com

Credit Card Authorization

Please fill out the details as indicated below to place your credit card on file.

Patient Name: _____ Date of Birth: _____

Card Holders Name: _____
(Exactly as it appears on card)

Billing Address: _____

City, State, Zip _____

Card No: _____

Card Expiration Date: _____

CVV (Security Code): _____

Card Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ Am Ex ☐ HSA/FSA

Email address: _____

Terms of Authorization

I authorize A&M Psychiatric Services PA d/b/a Gulf Coast Behavioral Health to charge the above card for any outstanding balances. This includes co-pays, deductibles, and balances left after insurance processing (Explanation of Benefits).

I understand this card information will be kept in a securely encrypted format, and an automated transaction receipt will be transmitted electronically to me on the date any charge is processed to the email address I've provided above.

Prior to initiating a dispute or chargeback with my financial institution, I agree to contact the office directly to resolve any billing inquiries by email at billing@gulfcoastbh.com or by phone at (727) 726-7442. I understand any unjustified chargebacks may result in the assessment of additional administrative and retrieval fees.

I understand this authorization will remain valid until the card expires or I revoke it in writing by email to billing@gulfcoastbh.com or by mail to Gulf Coast Behavioral Health, Attn: Billing Department, 1938 Soule Rd, Clearwater, FL 33759.

By signing, I hereby acknowledge that I have read, understand, and acknowledge all the above. I agree that a copy of my signature, including an electronic or typed signature, has the same legal effect as my original handwritten signature.

_____ _____
Cardholder Signature Date

Clear Form