

South Coast PSYCHIATRY

Psychotherapy & Medication Management

CREDIT CARD AUTHORIZATION

Please complete the following information.

I, _____, am authorizing South Coast Psychiatry, Inc. to charge
(print name)
my credit card in the event that I fail to show for a scheduled appointment, or do not give notification of my inability to attend a scheduled appointment at least 48 business hours in advance, as agreed to in the Treatment Consent Form. Furthermore, for outstanding payments of services rendered,

I authorize South Coast Psychiatry to charge my credit card for the full amount due. I will not dispute for sessions I have received or that I have not cancelled less than 48 business hours in advance.

I further authorize South Coast Psychiatry to disclose information about my attendance/cancellation to my credit card company if I dispute a charge.

Card Type (circle one): Visa MasterCard

Card #: _____ Expiration Date: _____

Name as Printed on Card: _____

Billing Address: _____
(Street, City, State & Zip)

Signature: _____ Date: _____
(client or financially responsible party)

This form will be securely stored in your clinical file and may be updated upon request at any time.

Please note, your credit card will not be charged unless the following conditions apply: no-show for a scheduled appointment, cancellation less than 48 business hours in advance, or participation in treatment (eg. appointment or phone session) without payment rendered.