**Credit Card Authorization Form**

In adherence to our clinic policy, we ask each patient to keep a credit card authorization form on file in the event that you cannot or do not pay fees that are outstanding or remain as part of your visit or as it pertains to any late/no show fees. In this event, we reserve the right to authorize your credit card. Your signature below indicates your agreement and consent to charge your credit card for any outstanding charges for any service fees which may include late cancellation fees, no show fees, phone services, and other fees as outlined in clinic policies and procedures. You will be notified in writing or via email of any charges made to your credit card account.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (print name as it appears on the credit card), authorize Psychiatry Online Canada to submit any charges for professional services that are rendered to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (print full legal name of patient receiving services) to my credit card. This authorization applies to all legitimate charges for any individual whom I have accepted financial responsibility and includes all current and future outstanding charges. I will update my credit card information when necessary.

Name on Credit Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Credit Card:

☐Visa

☐MasterCard

☐American Express

☐Discover

☐Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Number : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Verification Data:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(3 digits on back of credit card for most; American Express may be in front of card)

Zip Code applicable to Credit Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full legal name of patient authorized for use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Cardholder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_