CREDIT CARD AUTHORIZATION FORM

I allow Psychology Associates of Grand Rapids to electronically store my credit card information on file (choose one):

- ☐ Please use my stored credit card information to pay my balance in full on the 5th _____, 20th _____, both days _____.
  * I do___, do not, ____ need an emailed receipt after each transaction.
  * A monthly statement will not be mailed.*

- ☐ Please use my stored credit card information to process a monthly payment on my outstanding balance.
  * Please bill my card $_____/month until my balance is paid in full.
  * I would like my payment to be processed on the (please specify):
    5th ____ and/or 20th _____ day of the month. (Please note that due to holidays or weekends this day could vary by a couple of days later than you specify.)
  * I do___, do not, ____ need an emailed receipt after each transaction.

- ☐ Please use my stored credit card information to pay my copay and/or deductible at the time of my service.
  * I do___, do not, ____ need an emailed receipt after each transaction.

Patient Name: _____ DOB: _____
Cardholder Printed Name: _____
Cardholder Signature: _____

Email: _____

Date: _____

CC#: _____ Exp. Date:_____

CVV: _____

The credit card numbers listed above will be stored electronically in our billing system. Once they are entered the bottom portion of this form will be shredded.