CHILD AND ADULT PSYCHIATRISTS OF THE PENINSULA, INC.

CREDIT/DEBIT CARD AUTHORIZATION FORM

I authorize CHILD & ADULT PSYCHIATRISTS OF THE PENINSULA to retain the following credit card information and to charge my **VISA** or **Mastercard** account for:

[check one]

☐ Balance of charges at the close of each monthly billing

☐ $_____ for: ☐ this visit only
☐ all visits this year

I understand that this form is valid (1) through the expiration date of my credit card, or (2) through the duration of treatment, unless I cancel the authorization through written notice.

PATIENT NAME

CARDHOLDER NAME DAYTIME PHONE NUMBER

CARDHOLDER ADDRESS (AS IT APPEARS ON THIS CREDIT/DEBIT CARD'S BILLING STATEMENT)

CITY STATE ZIP

CREDIT CARD ACCOUNT NUMBER

☐ this card is a flexible spending plan (FSA) or health savings account (HSA) thru my employer.

EXPIRATION DATE 3-DIGIT CODE ON BACK OF CREDIT CARD

CARDHOLDER SIGNATURE DATE

[rev May 2014]