**CHILD AND ADULT PSYCHIATRISTS OF THE PENINSULA, INC. (CAPP)**
**CREDIT/DEBIT CARD AUTHORIZATION FORM**

| **PATIENT NAME** | | **DATE** | |
|---|---|---|---|

**I authorize CHILD & ADULT PSYCHIATRISTS OF THE PENINSULA (CAPP)** to retain this credit card information and to charge the following **VISA** or **Mastercard** account(s) for the patient portion due at the close of each monthly billing. I understand that this form is valid (1) through the expiration date of my credit cards, or (2) through the duration of treatment, unless I cancel the authorization through written notice. For information updates/revisions, I will notify my doctor or CAPP's Business Office and may need to complete a new authorization form.

☐ I have a Health Savings Account/Flexible Spending Account and will furnish ***BOTH*** HSA/FSA and General Credit Card information. CAPP will charge my HSA/FSA card for qualified medical expenses. If charges to the HSA/FSA account decline, my HSA/FSA funds exhaust, or for non-qualified medical expenses, CAPP will charge my General Credit Card. *[Complete both credit card forms; checkbox applicable type of card for each form.]*

☐ I am using a General Credit Card only. I do not have a Health Savings or Flexible Spending Account. *[Complete one credit card form only; checkbox "General Credit Card"]*

SPECIFY TYPE OF CREDIT CARD

☐ **HSA/FSA card** ☐ **General Credit Card**

*PRINT LEGIBLY*

| **CARDHOLDER NAME** | |
|---|---|
| | |
| **CARDHOLDER'S PHONE NUMBER** | |
| | |
| **ADDRESS** (AS IT APPEARS ON BILLING STATEMENT) | |
| | |
| **CITY, STATE, ZIP** | |
| | |
| **CREDIT CARD ACCOUNT NUMBER** (xxxx-xxxx-xxxx-xxxx) | |
| | |
| **EXPIRATION DATE** (MM/YYYY) | **3-DIGIT CODE** |
| | |
| **CARDHOLDER'S SIGNATURE** | |
| | |

SPECIFY TYPE OF CREDIT CARD

☐ **HSA/FSA card** ☐ **General Credit Card**

*PRINT LEGIBLY*

| **CARDHOLDER NAME** | |
|---|---|
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| | |
| **CARDHOLDER'S SIGNATURE** | |
| | |

[rev Sep 2019]