Authorization for Automatic Credit Card Payment

For your convenience, and to guarantee payment for services rendered, we request documentation of a major credit card.

I authorize Barrington Behavioral Health & Wellness to keep my signature on file and to charge my credit card account listed below for copays/coinsurance, not collected at time of service, and for any current outstanding account balances over 30 days following insurance determination, including fees due to late cancellation or not attending scheduled appointments.

I understand that this authorization is valid until I cancel the authorization through written notice to the health care provider or unless otherwise indicated.

Please note charge dates may not coincide with session dates. Statements may be provided at your request.

☐ Master Card ☐ Visa ☐ Discover ☐ Other: _____

Account # _____ Exp Date: _____ 3 Digit CVV _____

Patient Full Name: _____

Cardholder Name: _____

Address Line 1: _____ Phone: _____

Address Line 2: _____ Mobile: _____

City: _____ State: _____ Zip: _____

Cardholder Signature: _____ Date: _____

*** Please note: If the patient is under 18 and the parent is going to drop them off for appointments, we strongly encourage you to leave a credit card for copayments/coinsurance. Your copayment/coinsurance is expected at each visit.