

## **Credit Card Authorization**

As a convenience to you Evansville Psychiatric Associates will keep a credit card authorization on file to fulfill your financial requirements. This will ensure timely posting for your financial responsibility due at the time of service.

We will charge and post the amount due at the time of service for the patient due balances.

<input type="radio"/> MasterCard	<input type="radio"/> Visa	<input type="radio"/> American Express	<input type="radio"/> Discover
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Card Number:  	CVV:  
Card Holder Name: <hr/>	Expiration Date:  
Address: <hr/>	ZipCode:  
Card Holder Signature:  	

By signing this agreement I understand the terms and conditions listed above. I also understand that any charges incurred for treatment and are not included with this date's payments will be due at the next billing cycle. A receipt will be provided at the time of services upon my request.

This Credit Card Authorization is to be used for the following patient accounts:

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<hr/>	<hr/>
<hr/>	<hr/>

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 Today's Date

Scan/attach to each patient record as indicated; Billing/Payment:CCAuth