CREDIT CARD ON FILE AGREEMENT

This form authorizes Center for Behavioral Wellness to retain your valid credit card number on file. This form is confidential and only authorized staff will have access to your information. All credit card information will be stored and processed through a third party service, Complete Gateway.

Your credit card will be charged ONLY under the following circumstances:

- Center for Behavioral Wellness reserves the right to charge the credit card listed below for any co-pay due at the time of service. This notice serves as your consent for any co pay charges due at time of service.
- Center for Behavioral Wellness reserves the right to charge your credit card listed below for any balance older than 60 days from time of service.
- If you, as a patient, miss a scheduled appointment without 24-hour cancellation notice, Center for Behavioral Wellness reserves the right to charge the credit card listed below.
- If you, as a patient, request Center for Behavioral Wellness to process a payment to the credit card listed below.

Other than the conditions mentioned above, under NO circumstances will Center for Behavioral Wellness charge your credit card for anything not discussed personally with you. In conjunction with HIPAA regulations, all credit card information will be kept confidentially in a secure and locked location. Only authorized staff will be able to access this information.

ACKNOWLEDGED, AGREED & ACCEPTED

Having read this form and talked with the staff, my signature below acknowledges that I voluntarily give my authorization and consent to providing the requested information for my credit card to be charged for the conditions listed above. I understand that it is my responsibility to notify Center for Behavioral Wellness of any changes that need to be made to my credit card agreement by completing a new agreement. I understand that I reserve the right to revoke the use of this form by signing the designated area below.

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Card Holder Signature:_____ Date:_____

NAME AS IT APPEARS ON CREDIT CARD:_____

BILLING ADDRESS:_____

_____

VISA/MASTERCARD/DISCOVER/AMERICAN EXPRESS (circle one)

CARD #:_____ EXPIRATION DATE:_____

EMAIL (for receipt):_____

DO NOT COMPLETE (unless revoking credit card on file authorization):

If at any time you wish to revoke the use of this credit card for any payments you may be responsible for, please sign and date on the lines below.

Patient Signature:_____ Date:_____