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. Receipts will be provided upon request.

○ MasterCard	○ Visa	○ American Express	○ Discover

Is this an **HSA** or **FSA** Card? O Yes O No

(**Note**: Was this card provided to you by your medical insurance? If you are unfamiliar with these terms, the answer is usually "no.")

Card Number:	CVV:
Card Holder Name: _____ Address: Zip Code: _____ Signature:	Expiration Date:

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:

_____ _____

_____ _____

_____ _____

Date: _____

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