PRIME BEHAVIORAL HEALTH, LLC

Credit Card Authorization Form

I hereby consent for Prime Behavioral Health, LLC to charge my credit card listed below for co-pay, balance and deductible amounts that have not been paid by me in a timely manner. Co-pays and balances are due at the time of the visit, unpaid balances and deductibles are due within 2 weeks of the statement. I understand that Prime Behavioral Health, LLC will give me a call to collect any balances on the account and if I don't respond in 1 business day, my card would be charged accordingly and a receipt would be mailed to my address on file. Further, I consent for Prime Behavioral Health, LLC to charge my credit card for the missed appointment fee if I haven't cancelled the appointment 24hrs prior. Prime Behavioral Health, LLC will give me a courtesy call or leave a message with the amount before charging. I understand it is my responsibility to keep the phone number and address up to date on file with Prime Behavioral Health, LLC.

CARDHOLDER INFORMATION

Name: ____

Billing Street Address: ____

Street Address (cont.): ____

City: ____________________ State: _________ Postal Code: _______________

Country: _________________________ Email _________________________

Address: ____

Direct Telephone: (__) ______-__________

CREDIT CARD INFORMATION

Credit Card Type: □ MasterCard □ Visa □ American Express □ Discover Card

Number: ____

Expiration Month: ___ Expiration Year: ___

Cardholder Signature X ________________________ Date __/ ___/ ___

Security Code: ____________