MONARCH
BEHAVIORAL HEALTH, PLLC

Credit Card Payment Authorization Form

Please fill in all areas completely and sign and date the bottom.

Type of card (check one): _____ MasterCard _____ VISA
Is this a Debit Card? ___ Y ___N
Is this an HSA/FSA or Flexible Spending Account card? ___Y ___N

Name of Patient: _____

Name on the card (if different from patient): _____

Billing address of cardholder:

_____

_____

_____

_____

Credit card number: _____CVV: _____

Expiration date: _____

I, _____, authorize Monarch Behavioral Health, PLLC. to charge the credit card indicated above. I understand that unless I notify my clinician otherwise, my current account balance will be charged to this credit card after each session.

Patient's Signature

_____ _____
(Date)

Credit Card Holder's Signature (** if different than Patient)

_____ _____
(Date)