



## Credit Card Authorization

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I, the undersigned, authorize the Mind Health Institute, Newport Beach to charge my credit card in the event that I (or the party for whom I am financially responsible) fail to show for a scheduled appointment, or do not notify my provider at least 48 business hours in advance for a cancelled appointment, as agreed to in the Treatment Consent. Furthermore, for outstanding payments of services rendered, I authorize charges to my credit card for the full amount due. I agree to not dispute charges for any of these reasons and understand that clinical information will need to be released if a dispute is initiated. I further authorize my provider at the Mind Health Institute, Newport Beach to disclose information about my attendance and/or cancellation to my credit card company if I dispute a charge. This form will be securely stored in a clinical file and may be updated upon request at any time.

Card Type:    Visa    MasterCard    Discover    AMEX

Card #: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Verification/Security Code: \_\_\_\_\_

Name (as printed on card): \_\_\_\_\_

Billing Address: \_\_\_\_\_  
*(Street; City, State & Zip)*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Patient or financially responsible party)*

*\*Please note, your credit card will not be charged unless one of the following conditions apply: (a) no-show for a scheduled appointment, (b) cancellation less than 48 business hours in advance, or (c) participation in treatment (e.g., appointment or a phone/Skype session) without payment rendered.*

**PLEASE SIGN BELOW IF YOU PREFER YOUR CREDIT CARD TO BE CHARGED FOR REGULARLY SCHEDULED APPOINTMENTS:**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Patient or financially responsible party)*