Grayson Psychiatry
Child, Adolescent & Young Adult Behavioral Health

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Credit Card Authorization Form

I, _____, authorize **Jillianne Grayson, MD** to charge my credit card
PARENT/GUARDIAN NAME
for appointments and other authorized services provided to_____.
PATIENT NAME
I understand that my credit card will be charged the fees as agreed upon in the Office Policies Form. In the event of **missed appointments, cancellations, or changes in an appointment with less than one business days' notice, I will be charged the usual session's fee**. I understand that if I would like to pay with check, I can bring that payment at the time of the session; otherwise, my credit card will be charged. I understand that if I chose to use an HSA/FSA card I must have a backup credit card on file as well. This form will be securely stored in my clinical file and may be updated upon request at any time.

_____ _____
Signature of Card Holder Date

PRIMARY CREDIT CARD INFORMATION

CARD HOLDER'S FULL NAME: _____

CARD HOLDER'S BILLING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TYPE OF CREDIT CARD: HSA FSA VISA MASTERCARD AMERICAN EXPRESS OTHER _____

CREDIT CARD NUMBER: _____

EXPIRATION DATE: _____ SECURITY CODE: _____

SECONDARY CREDIT CARD INFORMATION (IF PRIMARY IS HSA/FSA)

CARD HOLDER'S FULL NAME: _____

CARD HOLDER'S BILLING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TYPE OF CREDIT CARD: VISA MASTERCARD AMERICAN EXPRESS OTHER _____

CREDIT CARD NUMBER: _____

EXPIRATION DATE: _____SECURITY CODE: _____