EMPOWERING
MINDS TOGETHER

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# CREDIT CARD AUTHORIZATION FORM

Print and complete this form

All this information will remain confidential

Empowering Minds Together, INC requires you to provide your credit/debit card information on file with us so we can automatically charge any co-pays, co- insurance, deductible amounts, and professional service charges such as late cancellation or missed appointment charges. It is the client's responsibility to keep cards accurate and up to date. We store financial information and other protected health information in an encrypted, HIPAA compliant site.

DISCLAIMER :
By typing your name below , you are signing this form electronically . You agree that your electronic signature is the legal equivalent of your manual signature l on this document.

Name on the Card: _____

Billing Address: _____

Credit Card Number: _____

Credit Card Type: ☐ Visa ☐ Mastercard ☐ Discover ☐ Other

Expiration Date: _____

Card Identification Number: _____(the last 3 digits located on the back of the card)
Amount to Charge : Any balance assigned by Insurance as Patient Responsibility

I authorize Empowering Minds Together INC. to charge the amount my insurance assigned as my responsibility to the credit card provided herein. I agree to pay for these Psychotherapy services in accordance with the issuing bank card holder agreement.

Signature: _____

Print Name : _____

Date: _____