Credit Card Authorization Form

This information will be used to provide reimbursement for services rendered and/or ensure payment in the event reimbursement is not made by an insurance company. Please provide the following information.

Card Type: ____Visa ____ MasterCard ____ Discover ____AmEx ____HSA

Name as it appears on card: _____

Billing address:

_____

Street Apt/Unit #

_____

City State Zip

Credit Card Number: _____

Expiration Date: _____ CVV: _____

I hereby authorize Central Psychological Services, LLC (CPS) to keep my credit/debit card information on file and automatically charge my card my account for fees related to services rendered. These fees include, but are not limited to: professional services, insurance copays, deductibles, services not covered by my insurance, premature cancellation or "no show" fees, and/or self-pay fees. This authorization is valid until I provide CPS with a written notice of cancellation.

_____ _____

Client Signature Date

_____

Client Name Printed

_____ _____

Witness Signature Date

6335 S. East St.
Indianapolis, IN 46227

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