Credit Card Authorization Form

Completion of this form indicates that you authorize Linden BP to charge your credit card for:

1) The consultation appointment IF you do not attend and/or cancel with less than 48-business hours.

2) A balance on the account that is not paid within 30 days.

The credit card will only be charged for fees when efforts to collect payment in a timely manner have been unsuccessful as outlined by the Psychological Service Agreement. It is my responsibility to update my records should my credit card be cancelled or expire. And in the event a card is declined or has insufficient funds, I will still be responsible for payment and any associated late fees. I agree not to dispute charges for services that I/my child has received, or that I have not cancelled with appropriate notice. If I do dispute the charge, then I understand that Linden BP may disclose information about my/my child's attendance/cancellation to the bank in order to ensure payment.

I have provided the credit card information listed below. The terms outlined in this form have been explained to me and I have provided verbal consent. The completion of this form serves as my written confirmation and my credit card will remain on file as long services are provided at Linden BP.

_____

Patient Name

_____

Cardholder Name

_____

Cardholder Billing Address City State Zip

_____ _____ _____

Credit Card Number Exp. Date CVV