

## Cruz Clinic/Integrative Psychology Credit Card Authorization Form

\_\_\_\_\_  
Patient Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient Date of Birth

Visa    MasterCard    Discover    American Express

\_\_\_\_\_  
Cardholder Name

\_\_\_\_\_  
Cardholder Address

\_\_\_\_\_  
City                      State                      Zip

\_\_\_\_\_  
Credit Card Number

\_\_\_\_\_  
Expiration Date                      Security Code

I AUTHORIZE CRUZ CLINIC TO CHARGE MY CREDIT CARD FOR PAYMENT/S TO BE PROCESSED:

- AT EACH TIME OF SERVICE                       TOTAL BALANCE ON LAST DAY OF MONTH  
 PER PAYMENT AGREEMENT \$ \_\_\_\_\_

PLEASE READ AND INTIAL BELOW:

\_\_\_\_\_ HAVING READ THIS FORM, MY SIGNATURE BELOW ACKNOWLEDGES THAT I VOLUNTARILY GIVE MY AUTHORIZATION AND CONSENT TO PROVIDING THE REQUESTED INFORMATION FOR MY CREDIT CARD TO BE CHARGED ACCORDINGLY FOR THE CONDITIONS LISTED ON THIS FORM.

\_\_\_\_\_ I UNDERSTAND THAT THIS FORM IS VALID UNTIL \_\_\_\_\_ (DATE/YEAR) UNLESS I CANCEL THROUGH WRITTEN NOTICE TO CRUZ CLINIC.

\_\_\_\_\_ OTHER THEN THE CONDITIONS MENTIONED IN THIS FORM, UNDER NO CIRCUMSTANCES WILL CRUZ CLINIC CHARGE YOUR CREDIT CARD FOR ANYTHING OTHER THEN WHAT IS LISTED ON THIS FORM. IN CONJUNCTION WITH HIPAA REGULATIONS, ALL CREDIT CARD INFORMATION WILL BE CONFIDENTIALLY KEPT AND ONLY AUTHORIZED STAFF WILL BE ABLE TO ACCESS THIS INFORMATION.

\_\_\_\_\_  
Patient signature or authorized person

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

**RECIEPTS CAN BE MAIL TO:**    ADDRESS IN ACCOUNT    THE CARDHOLDER'S ADDRESS