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 AUTHORATION 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

N:forms/ patient forms/ Credit card auth form