Psychological Resource Associates

www.pratherapists.com

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(530) 756-0555
(530) 756-1368 - Fax

285 W. Court St. Ste. 202
Woodland, CA 95695
(530) 661-1733

Authorization To Use Credit Card

I authorize _____ of Psychological Resource
[Therapist]
Associates to keep my signature on file and to charge my Visa or MasterCard account for:

☐ Monthly balance of charges due by patient and/or guarantor.

☐ Balance of charges not paid by insurance within 90 days and not to exceed $ _____ per visit.

☐ Recurring charges (on-going sessions) of $ _____ monthly from the start date _____ to the end date _____.

I understand that this form is valid for one year from the date of signing unless I cancel the authorization through written notice to the above mental health provider.

Patient Name: _____

Credit Cardholder Name & Address:

_____

_____

_____

Credit Card Account Number: _____

Card Expiration Date: _____

3-digit Security Code: _____

Receipts for each transaction will be mailed to the credit cardholder's address as indicated above.

Cardholder's Signature: _____

Date: _____