Stephens Psychiatry

Jeff Stephens, MD | Cara Reeves, PhD

Payment Authorization Form

Patient Name: ______ **Date of Birth:** ______

Card Information:

Name on Card: ______ **Is this an HSA or FSA?** ______

Card Number: ______ ______ ______ ______

Expiration Date: ______ **Security Code:** ______ **Billing Zip Code:** ______

- **I hereby authorize Stephens Psychiatry to charge this card for services rendered and any balances including session fees, administration fees, and no-showed appointments.**
- I authorize Stephens Psychiatry to charge my credit card through CARDX. I understand that there is no fee for me to use a debit card, and there is a 3.5% processing fee for me if I use a credit card.
- The card processing system will automatically recognize the card for what it is, debit or credit.
- I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Stephens Psychiatry in writing of any changes in my account information or termination of this authorization.
- I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my bank or credit card company as long as the transactions correspond to the terms indicated in this authorization form. I acknowledge that credit card transactions could be linked to Protected Health Information.
- I verify that the credit card information provided above is accurate to the best of my knowledge. If this information is incorrect or fraudulent, or if my payment is declined, I understand that I am responsible for the entire amount owed and any additional costs incurred if denied

Signature: ______ **Date:** ______

Card Holder Name: ______