



**EXCELLENT CARE
PSYCHIATRY**

Excellent Care Psychiatry Credit Card Payment Authorization Form

Patient Name: _____

Billing Address: _____

(No PO Box)

City: _____ **State:** _____ **Zip code:** _____

Phone Number: _____ **Cell Number:** _____

Credit Card Type: ___MasterCard ___ Visa ___ Discover ___ American Express

Credit Card Number: _____ **Expiration Date:** _____

CVV: _____ **Billing Zip code:** _____

Account Balance: \$ _____ **Amount Charge:** \$ _____ **Remaining Balance:** \$ _____

I authorize Excellent Care Psychiatry to bill this card for the amount listed above.

Monthly Charged _____ **Paid by Phone** _____ **In Person** _____ **By Mail** _____

Patient Signature: _____ **Date:** _____

Office Representative: _____ **Date:** _____