CREDIT CARD AUTHORIZATION FORM

Providing Tranquility with a credit card to keep on file ensures that you will not accumulate a large balance with our office due to unpaid copays, co-insurances, or deductibles. Please note, copays, co-insurances, and deductible amounts are due at the time of service and your card will be charged the day of your appointment for these fees. Should your insurance not cover the remainder of the balance due, you will be sent a statement, which you will have 30 days to pay. After 30 days, if the bill remains unpaid, the credit card on file will be charged.

Your ability to dispute a charge or question your insurance company's determination of payment will remain unchanged.

If you have any questions about our policy, please do not hesitate to ask.

By signing below, I authorize Tranquility Psychiatry and Counseling Services to keep my signature and my credit card information securely on-file in my account. I authorize Tranquility Psychiatry and Counseling Services to charge my credit card for any amounts due at the time of service and any outstanding balances as outlined above. These could be amounts resulting from copays, co-insurances, deductibles, non-covered services, or denials for no coverage/eligibility but are not limited to these scenarios. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated on this form.

☐ Visa ☐ Mastercard ☐ American Express ☐ Discover

Card number: _____ Expiration date: _____

Name on card:_____

Billing zip code: _____ CVV (3 or 4 digit code on back of card):_____

Patient(s) you authorize this credit card for:

Patient name:_____ Date of birth:_____

Patient name:_____ Date of birth:_____

Patient name:_____ Date of birth:_____

_____ _____

Signature of Card Holder Date