Credit Card Authorization Form

We require keeping your credit or debit card on file as a convenient method of payment when authorized.

_____ I authorize Brightland Health to charge my credit/debit card for services not paid by my insurance company within 90 days from services rendered, including copays/deductibles/coinsurance/cancellation fees as outlined in the “Psychiatry and Psychotherapy fees” form.

Visa MasterCard Amex Discover (circle one)

Name on Card _____

Card Number _____

Expiration Date _____

CVV Code _____

Address _____

Zip Code _____

I understand that this form is valid without expiration unless I cancel this authorization by notice in writing submitted to Brightland Health.

Signature of Card holder: _____

Date: _____