COGNITIVE THERAPY ORANGE COUNTY

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Credit Card Billing Authorization Agreement

Please read the following carefully. When signed, this document will be an agreement between you and Cognitive Therapy and Consulting Associates/Cognitive Therapy Orange County (CTCA/CTOC).

I (Patient or Responsible Financial Party) authorize CTCA/CTOC to charge my credit card for services provided.

I also understand and agree that my credit card will be billed for missed appointment not cancelled more than 24 hours before the appointment start time.

Please note:

Appointments scheduled on the first business day after weekends or holidays must be cancelled prior to the start of the weekend or holiday in order to avoid a late cancellation charge.

Example: a Monday, 9:00 a.m. appointment must be cancelled by Friday 9:00 a.m.

In the event of a Disputed Charge, I or the Responsible Financial Party authorizes CTCA/CTOC to provide any patient information requested by the credit card processing company in order to resolve the dispute. Information provided may include but is not limited to: your name, date of birth, dates of service, Common Procedural Terminology codes, and/or payment history. I agree to hold CTCA/CTOC harmless from any claim should such a disclosure occur.

Credit Card Type: □ Visa □ MasterCard □ American Express □ Other

Credit Card Number

(Visa / MasterCard): ___-___-___-___ ___-___-___-___ ___-___-___-___ ____-____-___-___

(American Express): ___-___-___-___ ___-___-___-___-___-___ ___-___-___-___-___

Credit Card Expiration: ____-_____

Credit Card CVV number: ___-___-___ or ___-___-___-___

Credit Card Billing Zip Code ____-____-____-____-____

If CTCA/CTOC is unable to process your credit card, additional appointments will not be scheduled until the balaance due is paid in full.

Patient Printed Name: _____ Date: _____

Patient Signature: _____