Cruz Clinic/Integrative Psychology
Credit Card Authorization Form

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Patient Name Patient Date of Birth

□ Credit □ Debit □ HSA/FSA

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Cardholder Name

____

Cardholder Address

____

City State Zip

____

Credit Card Number

____

Expiration Date Security Code

PLEASE READ AND INTIAL BELOW:

________ I AUTHORIZE CRUZ CLINIC TO CHARGE MY CREDIT CARD FOR PAYMENTS TO BE PROCESSED AT TIME OF SERVICE.

________ HAVING READ THIS FORM, MY SIGNATURE BELOW ACKNOWLEDGES THAT I VOLUNTARILY GIVE MY AUTHORATION AND CONSENT TO PROVIDING THE REQUESTED INFORMATION FOR MY CREDIT CARD TO BE CHARGED ACCORDINGLY.

________ I UNDERSTAND THAT THIS AUTHORIZATION IS VALID UNTIL I PROVIDE A WRITTEN REQUEST FOR REMOVAL.

________ OTHER THEN THE CONDITIONS MENTIONED IN THIS FORM, UNDER NO CIRCUMSTANCES WILL CRUZ CLINIC CHARGE YOUR CREDIT CARD FOR ANYTHING OTHER THEN WHAT IS LISTED ON THIS FORM.

IN CONJUNCTION WITH HIPAA REGULATIONS, ALL CREDIT CARD INFORMATION WILL BE CONFIDENTIALLY KEPT AND ONLY AUTHORIZED STAFF WILL BE ABLE TO ACCESS THIS INFORMATION.

By typing my name below, I understand and agree that this form of electronic signature has the same legal force and effect as a manual signature.

____ ______________________

Signature of Patient/Parent/Guardian Date

____ ______________________

Signature of Witness Date

RECIEPTS CAN BE MAIL TO: □ ADDRESS IN ACCOUNT □ THE CARDHOLDER'S ADDRESS