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.

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 appointments not cancelled more than 24 hour prior to the appointment start time.

Please note: Appointments scheduled on the first business day after weekends or holidays must be cancelled the previous business day before the start of the weekend or holiday.

This authorization agreement and the information contain herein will be placed in the patient chart. This authorization agreement will be destroyed upon the conclusion of treatment services or at the request of the card holder.

Credit Card type: _____

Credit card number:

(Visa/MasterCard) ___-___-___-___ ___-___-___-___ ___-___-___-___ ___-___-___-___

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

Credit card expiration: _____-_____

Credit card CVV number: ____-_____-_____ or ____-____-____-____

Credit card billing zip code: ___-___-___-___-___

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

Patient Printed name:_____ Date: _____

Patient Signature: _____