TAMPA BAY

PSYCHIATRIC SERVICES, PL

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Credit Card Payment Authorization

I, ______________________________________, authorize Tampa Bay Psychiatric Services, PL

☐ to charge my credit card for the services rendered in the amount of $____________________

OR

☐ to charge my credit card refundable deposit fee of $100 to secure first time appointment. This money will be applied towards my balances at the first appointment. If there is no balance, money will be refunded back to the credit card. If appointment is cancelled with 48 hours advanced notice, deposit will be fully refunded.

____
Signed   Date

____
Patient name and DOB

____

Credit Card information:

Credit card: Visa _____ Master Card______ Discover ______

Name on the card:____

Card number ____

Expiration date ______________________________**Billing Zip code**______________________

Security code ____