



CREDIT CARD AUTHORIZATION

Meridian Psychiatric Partners, LLC billing policy requires that a credit card be on record for balances that are more than 60 days due.

My signature authorizes Meridian Psychiatric Partners, LLC to charge my credit card for any balance that is more than 60 days overdue. I understand that this amount may include charges for appointments not cancelled 24 hours in advance and for charges not covered by insurance, if applicable.

If you do not wish to provide a credit card, you are required to pay in full at the time of service.

Name on Card: _____

Credit Card: Visa MasterCard American Express

Card Number: _____

Expiration Date: _____ Security Code: _____

Signature: _____

Printed Name: _____

Date: _____