UTAH PSYCHOLOGICAL ASSOCIATES
Credit Card Authorization Form

Please indicate the card you wish to use for services rendered through this practice. Charges will be deducted from the card designated below for No Show and Late Cancel charges. If client desires, card will also be billed for copays after relevant insurance has been billed and processed. We accept: Visa, Mastercard, Discover, and AMEX, HSA and Flex account cards that carry a Visa, MC or Discover logo. We also accept Care Credit cards.

Client Name: _____

Name as it Appears on the Credit Card: _____

Type of Credit Card: ☐ MasterCard ☐ Visa ☐ Discover ☐ Amex

Card Number: _____

Expiration Date: _____

Complete Card Billing Address (if different than client address on file):

_____

I, _____ authorize the above medical practice to process the above credit card as "Card on File" for such payments as Late Cancels, No Shows, copays, etc. I understand this authorization will remain in effect until the expiration of the credit card account. Client may also revoke this form by submitting a written request to the medical practice.

_____ _____

Cardholder's Signature Date