Seaside Behavioral Health
CREDIT CARD PAYMENT AUTHORIZATION

Our office requires that a credit card be kept on file for payment of any copays, co-insurance, deductible, or charges that may not be covered by your health insurance. These charges will occur the day of your appointment and will include Telepsych appointments. A receipt for each payment can be provided via email if desired. By signing below you agree that no prior notification will be provided.

I, ________________________, authorize Seaside Behavioral Health, LLC to charge my
(Full Name)
Credit Card or Bank Account for services provided to me while in treatment.

Billing Information

Billing Address ____________________________ Phone # _______________________

City, State, Zip ____________________________ Email _________________________

Credit Card

☐ Visa ☐ MasterCard

☐ Amex ☐ Discover

Cardholder Name ________________

Account Number ________________

Exp. Date _______ / _______

CVV _______

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the merchant in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that the merchant may at its discretion attempt to process the charge again within 30 days, and agree to an additional $25 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

AUTHORIZED SIGNATURE ___________________________ DATE _____________

PRINT NAME ___________________________