



## Payment Authorization Form

**M**any of our patients have asked for their credit cards to be kept on file as a convenient way to pay their fees. We would like to make this available to everyone. Paying by credit card or our FSA debit card will help keep track of yearly medical costs. It will also eliminate the need to wait to "check-out" at the end of your session- many of our patients are racing off to work or other appointments.

We accept Visa and MasterCard. You may also keep your flex-spending debit card on file. Credit Card numbers are kept securely and charges will appear on your statement as HPA. Your card will be charged, in most cases, the same day as your session. If a receipt is required it can be mailed or picked up at your next session.

If you'd like to take advantage of this service please complete and submit the following form.

Thank you!

### Patient Information

name of patient \_\_\_\_\_

self       spouse  
 parent     other  
card holder's relationship to patient \_\_\_\_\_

### Credit Card Information

name of card holder \_\_\_\_\_

Mastercard  
 Visa

credit card number \_\_\_\_\_ expiration date \_\_\_\_\_ CVV \_\_\_\_\_

address of card holder \_\_\_\_\_ phone number of card holder \_\_\_\_\_

### FSA Debit Card Information

name of card holder \_\_\_\_\_

Mastercard  
 Visa

credit card number \_\_\_\_\_ expiration date \_\_\_\_\_

address of card holder \_\_\_\_\_ phone number of card holder \_\_\_\_\_

I agree to allow Hudson Psychiatric Associates to charge my credit card or FSA debit card on the day of the service provided. I understand I may revoke this consent at any time by providing a written statement. I understand that it is my responsibility to provide at least 48 hours (including two full business days) notice for cancellations and that I will be charged for any missed sessions. My signature below verifies that the above card is valid and that I am authorized to use this credit card.

signature of card holder \_\_\_\_\_ date \_\_\_\_\_