Psychiatric Wellness Center

30300 Agoura Road, Suite 195, Agoura Hills, CA 91301
P: 818-532-7950 F: 818-532-7685

CREDIT CARD AUTHORIZATION CONSENT FORM

I, ____ hereby authorize Psychiatric Wellness Center to charge my credit card for my appointment copayments.

Type of Card: ☐ Visa ☐ Mastercard ☐ Discover ☐ AMEX

Credit Card Number: ____

Expiration Date: ________________ CVC: ________________

Name of Cardholder: ____

Card Billing Address: ____

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Amount to be charged: $____________________

Pharmacy Name: ____

Pharmacy Phone number: ____

By signing this, I acknowledge the charges described on this form, assume full responsibility for said charges, and agree to honor and abide by the terms of payment. I acknowledge and accept Psychiatric Wellness Center's terms and conditions.

Authorized Signature of Cardholder: ____

Date: _______________________