Psychiatric Alternatives & Wellness Center

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Credit Card Consent Form

Psychiatric Alternatives and Wellness Center keeps credit card information on file in order to make payments for doctor visits easy and convenient. Your credit card information will be kept strictly confidential.

Card Type: American Express Discover MasterCard Visa

Credit Card Number: _____

Name on Credit Card: _____

Expiration Date: _____ /_____

I consent to allow Psychiatric Alternatives and Wellness Center to store my credit card information on file and charge my credit card:

1) For insurance co-pays, coinsurance, and unmet deductible associated with my/ my child's doctors visits.

2) For any missed appointments with a doctor (that were not canceled by phone, email, or online two business days or 48 hours prior to the scheduled session time), my credit card will be charged $150 for missed psychiatry appointments and $100 for missed psychotherapy appointments.

3) I also understand that if any charges on my credit card are shown to be incorrect, Psychiatric Alternatives and Wellness Center will issue the appropriate refund to my credit card.

Patient Name: _____ Patient's DOB: _____

Card Holder's Name: _____ Phone Number: _____

Card Holder's Signature: _____ Date: _____