THE PSYCHIATRY AND PSYCHOLOGY CENTER

650 GRISWOLD ST, NORTHVILLE, MI 48167
PHONE (248) 912-0080
FAX (248) 912-0208
EMAIL: REFILL@NOVIPSYCH.COM

CREDIT CARD CONSENT

I authorize The Psychiatry and Psychology Center to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐ Visa ☐ MasterCard ☐ Discover

Credit Card Number _____

Expiration Date _____ / _____ **CVV/CVC** _____

Cardholder Name_____

Billing Address _____

City _____ **State**_____ **Zip** _____

☐ I (we), the undersigned, authorize The Psychiatry and Psychology Center to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by The Psychiatry and Psychology Center

This authorization will remain in effect until I (we) cancel this authorization.

OR

☐ I (we), the undersigned, authorize The Psychiatry and Psychology Center to charge my credit card, indicated above, for a one-time transaction of: $_____

Card Holder Name (Print):

_____

Relationship to Patient:

_____

Card Holder Signature:

_____

Patient Name:

_____

Date:

_____ / _____ / _____