LODESTONE
CENTER FOR BEHAVIORAL HEALTH

Credit Card Authorization

Client Name: _____ Date of Birth:_____

The information gathered below is used for the purpose of co-pays/deductible payments/co-insurance payments incurred at The LodeStone Center for Behavioral Health at time of service. Please complete the form below and choose the best option for your account. If you prefer your card not be saved, please check *Do Not Save My Credit Card Information*, and Initial, with the date.

OPT OUT:
☐Do Not Save my Credit Card Information. X _____ Date: _____

OPT IN:
☐Please, save my card on file, but do not run it without my verbal permission.

☐Please, put the following information on file to run at time of service.

Card type(Circle One): Visa/MC/Amex/Discover

Cardholder Name: _____ Phone Number: _____

Card Number: _____ Expiration Date: _____ /_____

Security Code: _____ Billing Zip Code: _____

Cardholder Signature: _____ Date: _____

By signing, you are providing permission for payments to be drafted from your account (when verbally indicated during appointment check-ins, or otherwise agreed upon) and applied toward the above person's account.