

## Credit Card Authorization

Securely keep a card on file for copays and balances.

I authorize 360 Talk Therapy to charge the credit/debit card listed below for copays, deductibles, no-show fees, and balances due on my account.

**Patient Name**

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**Cardholder Name**

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**Card Number**

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**Expiration (MM/YY)**

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**CVV**

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**Billing ZIP**

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### Card Type

- Visa
- Mastercard
- American Express
- Discover
- HSA / FSA

This authorization remains in effect until I provide written notice to revoke it. I understand charges will be processed only for services rendered or fees outlined in the practice's financial policy.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_