Peachtree Comprehensive Health
TEL 404.351.2008 FAX 404.351.0243 WEB PCHPROFESSIONALS.COM

# CREDIT CARD AUTHORIZATION FORM

***If needed... Fax back to PPP/PDBT at (404) 351-0243***

For my convenience, the undersigned form does hereby authorize Peachtree Comprehensive Health (Peachtree Psychiatric Professionals, Peachtree Cognitive Center, and/or Peachtree DBT) to process the above credit card I have verbally provided as "Signature on File" for psychiatric services.

***Process***

**By executing this document, it will not be necessary for me to sign each and every credit card voucher.** This authorization is valid until such time as written notice of revocation is received by Peachtree Psychiatric Professionals, Peachtree Cognitive Center, and/or Peachtree DBT. Upon receipt of written notice of revocation, Peachtree Psychiatric Professionals, Peachtree Cognitive Center, and/or Peachtree DBT will charge my credit card for any outstanding balances covered under this authorization form.

Patient's Name: _____ Name of Provider(s):_____

**Please charge to the following Credit Card (please circle): MasterCard Visa American Express Discover**

_____ _____ / _____ _____
**Credit Card Number** **Expiration Date (mm/yy)** **CVV (Security ID #)**

_____
**Name as it appears on the Credit Card (PLEASE PRINT)**

_____
**Cardholder's Billing Address (as Listed with the Credit Card Company)**

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

***Please list below the names of individual(s) other than the cardholder authorized to use this card.**
*This would include any and all persons also receiving services at the practice for whom you would like this card to be used.*

**(PLEASE PRINT)**

_____

_____

_____

_____

**EMAIL** (to receive transaction receipts)**:** _____

***I have read this agreement and agree to the terms and conditions stated above.***

**Signature of Cardholder:** _____ **Date:** _____