Mind Health Center, LLC
5700 West Grace St., Suite 105-A
Richmond, VA 23226
804-442-3116
www.mindhealthcenter.net

Credit Card Authorization Form

I am providing my debit or credit card information below for the purpose of paying for my sessions at the Mind Health Center under the following conditions:

- My card will be charged for applicable copays and session fees after each appointment held, or fees for sessions missed that I do not cancel with 24 hours notice prior to the appointment.
- My card will be charged if a balance accrues due to an unpaid balance from the insurance company, or if a check is returned unpaid. I understand I will be charged an additional $25 service fee if a check is returned. I understand that will be charged an additional $25.00 service fee per occurrence for any credit card charges that are challenged and proven to be accurate charges.
- I am also responsible for any charge back fees if, for some reason, my credit card is declined. They must be paid within 7 days of being notified of such charges and paid by check or cash.
- I may opt at any appointment to pay by cash or check in lieu of debit or credit card.
- This authorization becomes a permanent part of my records and will be treated with privacy, confidentiality, and the utmost financial safeguards for the length of time my records are required by law to be retained (up to 7 years).

I, _____ (client or guardian of minor) am authorizing the Mind Health Center, LLC, to use my credit card information to charge my credit card in the event that I do not notify my clinician of my inability to attend a scheduled therapy appointment, and do not cancel my appointment at least 24 hours in advance, if a check is returned for any reason, or there is any outstanding balance.

Type of Card: VISA ☐ MasterCard ☐ Discover ☐ AMEX ☐

Card Number: _____

Verification/Security Code:_____ Exp. Date: _____/_____ Zip Code:_____

By signing below I am authorizing the Mind Health Center, to charge for scheduled appointments or outstanding balances.

Client or Guardian's Signature:_____ Date:_____