the COLLECTIVE
INTEGRATED BEHAVIORAL HEALTH

Revised 04/27/2022

Payment Authorization Form

I, _____ ,Date of Birth: ____/____/_____ ,

agree and authorize The Collective to save the cards indicated below on file. I acknowledge that two active cards must be kept on my file. I acknowledge that, even if I do not have a copay due at time of service, I must keep two active cards on file. By signing this agreement, I understand that any co-pay, co-insurance, deductible amount, no-show fee, or any other fee charged by my insurance or the practice will be charged using my preferred payment method. If my preferred payment method is not successfully charged, I authorize The Collective to charge my second payment method on file.

Cardholder Name: _____

Billing Address: _____

_____

Card #1 (Preferred Payment Method):

Type of Card: ☐ Visa ☐ Mastercard ☐ Amex ☐ Discover ☐ Other:

Number: _____

Expiration Date (mm/yy): _____/_____ CVC: _____

Card #2:

Type of Card: ☐ Visa ☐ Mastercard ☐ Amex ☐ Discover ☐ Other:

Card Number: _____

Expiration Date (mm/yy): _____/_____ CVC: _____

I authorize The Collective to process the card above as "Card on File" and charge in accordance with the agreed upon payment plan between the practice and me (e.g. one time charge, monthly payment plan, etc). I understand this authorization will remain in effect until the expiration of the credit card account. Client may also revoke this form by submitting a written request to the medical practice.

_____ _____ _____

Cardholder's Signature Cardholder's Printed Name Date