Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information				
Card Type:	☐ MasterCard	☐ VISA	☐ Discover	☐ AMEX
	☐ Other ________________________________			
Cardholder Name (as shown on card): ________________________________				
Card Number: ________________________________				
Expiration Date (mm/yy): ________________________________	CCV #: ___________			
Cardholder ZIP Code (from credit card billing address): ________________________________				

I,____, authorize **Desert Sage Health, PLLC** to charge my credit card above for agreed upon copay, co-insurance, deductible or account balance. I understand that for telehealth session my credit card will automatically be charge for the full member responsibility for each session. I understand it is my responsibility to understand the amount I am financially responsible for each session either through contacting the front office or calling my insurance company directly. If I have an additional balance I will be called and verbally authorize an amount to be charged before my card is charged. I understand that my information will be saved on file for future transactions on my account.

____ _____________

Cardholder's Signature Date

Client(s) name (if different from card holder): ____

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