**Payment Responsibilities and Credit Card Authorization Form**

It is the responsibility of each client to render payment for treatment at the time of service. Clients are responsible for all co-pays, coinsurance, deductible, self-pay rates, no-show fees and remaining balances following insurance reimbursement. **All clients** must have a valid credit card on file while receiving services at MMBHS. As a courtesy to you, MMBHS will charge your credit card on file for the balance on your account.

With this authorization, you authorize regularly scheduled charges to your card at the time of service with an additional $2 service fee.

Any charges will appear on your credit card statement and a receipt will be sent to the email address provided. 

MMBHS reserves the right to freeze access to services if two (2) or more payments have been missed or if payment to your card fails. Services can resume only after the unpaid balance is zero and/or by completing a repayment plan with the accounting department. The billing department can be reached at 410-766-6624.

If the credit card fails to authorize, or there is any other difficulty using this information to process the payment, information will be sent to the client requesting an alternative method of payment. To add another card, another completed authorization form will be required.​ If this is a replacement authorization, the balance may be charged immediately.

Please complete all fields. You may cancel this authorization at any time by contacting us to provide replacement card information. This authorization will remain in effect until cancelled or client is discharged.

**Credit Card Information**  
Card Type: ☐ MasterCard               ☐ VISA                  ☐ Discover                  ☐ AMEX       □ Other 

Cardholder Name (as shown on card): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date (mm/yy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  CVV (3 Digit code on back):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardholder ZIP Code (from credit card billing address): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address (for receipt to be sent): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_, authorize M & M Behavioral Health Solutions to charge my credit card above for services rendered. I understand that my information will be saved to file for transactions on my account.

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature: ­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_