Please complete the following information.

By signing this form I am authorizing PDX Mental Health Resources, LLC to charge my credit card for any services rendered as agreed to in the Medication Policy Form. I also authorize PDX Mental Health Resources to charge my card in the event I fail to show for a scheduled appointment, or do not give notification of my inability to attend a scheduled appointment at least 48 business hours in advance. Furthermore, for outstanding payments of services rendered, I authorize PDX Mental Health Resources, LLC to charge my credit card for the full amount due. I will not dispute for sessions I have received, or for sessions I have cancelled less than 48 business hours in advance.

I further authorize to disclose information about my attendance/cancellation to my credit card company if I dispute a charge.

I acknowledge that I am aware there is a $25 fee for any declined credit card charge.

Card Type (check one): Visa MasterCard

|  |  |  |  |
| --- | --- | --- | --- |
| Card number: | | | |
| Expiration Date: | | | |
| CID (3 digit number on back of card) | | | |
| Name as Printed on Card: | | | |
| Card Billing Address: | | | |
| Street: | City: | State: | Zip Code: |
| Signature: | Date: | | |

This form will be securely stored in your clinical file and may be updated upon request at any time. Please note, your credit card will not be charged unless the following conditions apply: no-show for a scheduled appointment, cancellation less than 48 business hours in advance, or participation in treatment (eg. appointment or phone session) without payment rendered.