ARISE
Psychiatric Medical Group

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Credit Card Authorization Form

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

Credit Card Information	
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other:	
Cardholder Name (as shown on card):	
Card Number:	
Expiration Date (mm/yy):	CVV:

By signing below, I authorize Arise Psychiatric Medical Group, Inc. (APMG) to keep the above-listed card on file. I also understand that my information will be used for future transactions on the account(s) of the patient(s) listed below. Furthermore, I am aware that if any of my personal information has changed, I am responsible for contacting APMG to ensure they have the most current information to contact me or process payments accurately.

*** we will ask for your verbal consent prior to any charges being applied to your account ***

_____ _____

Patient's Name & DOB Date

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Patient/Guardian Signature