H. E. B. Behavioral Medicine
Credit Card Authorization Form

Card Holder Information		
Card Holder Name:		
Address:		
City:	State:	Zip:
Telephone:	Alt. Telephone:	
Billing Address (if different from above):		
City:	State:	Zip:

Payment Authorization

Card Type: ☐Visa ☐Mastercard ☐Discover ☐American Express

Card Number:_____ Exp. Date:_____

Card Identification Number:_____
(This is the 3 digits on the back of your card)

I wish to authorize ongoing payments for sessions, missed appointments or late cancellations from H. E. B. Behavioral Medicine using this credit card authorization form. I further authorize H. E. B. Behavioral Medicine to maintain my card information on file. I agree that I will pay for these sessions or late cancellations and indemnify and hold H. E. B. Behavioral Medicine harmless against any liability pursuant to this authorization. I understand that my signature on this form will serve as authorized signature on the credit card charge slip. This authorization will remain in effect until such time when a written request to cease charges is received.

H. E. B. Behavioral Medicine will process all charges using a secure bank card service. Charges will be processed to the above stated account 1 to 5 business days after the session date or late cancellation.

CONFIDENTIAL

_____ _____ _____
Printed Name Signature Date

305 Miron Drive, Southlake, TX 76092 * 817.571.2899 * 817.329.3866
817.571.9879 (fax)