CWMHA
Central Wisconsin Mental Health Associates

CENTRAL WISCONSIN MENTAL HEALTH ASSOCIATES, SC

Payment Authorization Form

PLEASE SELECT: ☐ Visa ☐ Mastercard ☐ Discover ☐ Amex

Card Holder Name: _____

Client Name if different: _____

Card Number: _____

Expiration Date: _____Security Code: _____

Billing Address: _____

Card Holder State & Zip Code: _____

I, _____ authorize Central Wisconsin Mental Health Associates, SC to charge my credit card above for agreed upon services. I understand that my information will be stored for future transactions on my account. I understand that this card/bank account will be charged my patient responsibility as indicated on each EOB from my insurance company and in accordance with the late cancellation/no show policy.

This authorization will remain in full force and effect until Central Wisconsin Mental Health Associates, SC has received written notification from me of its termination in such a time and in such a manner as to afford us a reasonable opportunity to act on it.

_____ _____

Card Holder Signature **Date**

For office use only:

Date Terminated: