8224 Mentor Ave. Suite 208
Mentor, OH 44060
Phone: 440-392-2222   Fax: 440-565-2349
www.behavioralwellnessgroup.com
www.campustherapy.com

CREDIT CARD AUTHORIZATION FORM

DATE: ______________   PATIENT NAME: ____

The Behavioral Wellness Group/Campustherapy.com has my authorization to charge my card for balances not covered by insurance and for which I am personally responsible.
I also understand that a nominal fee of $10.00 will be assessed during the very first session only to cover any potential unexpected fees. If there are no fees due, my card will be refunded the $10.00.

CARDHOLDER NAME:________________________________   Zip Code ______________

(Circle one)   Visa   M/C   Disc   AmEx

LAST FOUR DIGITS OF THE CARD: ___________________   EXP. DATE: __________________

I hereby authorize Campustherapy.com to keep my debit or credit card or bank account information (as indicated above) on file for payment and to **initiate appropriate payment entries against the above referenced debit or credit card or bank account, as applicable, as amounts are owed by me on the Patient Account listed above**. I acknowledge that the initiation of all such entries to make payments on the Patient Account listed above must comply with the provisions of U.S law and any applicable state laws. I understand and agree that these entries may be made to my debit or credit card or bank account, as applicable, periodically to pay amounts owed by me on the Patient Account listed above. I also agree to notify Campustherapy.com if my debit or credit card, or bank account information (as indicated above) changes for any reason. This authorization shall remain in effect until the "End date of authorization" listed above or until I communicate to Campustherapy.com my intention to cancel this authorization by calling Campustherapy.com at (440) 392-2222 or writing to Campustherapy.com at 8224 Mentor Ave. #208 Mentor OH 44060. **In the event of returned ACH or a declined charge, my account will be charged a $10.00 service fee for each occurrence**. I acknowledge receipt of a copy of this authorization form.

________ I do not need notice prior to assessing my card

________ I wish to be given 24 hour notice prior to assessing my card via **(*select only one*)**

_____ phone call at the following number: _________ _________ ________________

_____ email at the following email address ____

CARDHOLDER SIGNATURE:____ Date:________________

******This Form is to be cross-shredded at first appointment to protect patient's privacy******

*Please note credit cards are processed under the name of **Cayan**.*   **Revised 6.19.19**