MINDPATH HEALTH

Credit Card Authorization

I authorize Mindpath Health to charge my credit card on file for amounts owed by me including co-pays, cancellations, and late fees. I understand that I will be sent receipts for credit card charges via mail or e-mail and that such charges will appear on my credit card statement. I understand that this Credit Card Authorization will remain in effect until I provide written notice of cancellation to Mindpath Health.

Patient Signature _____ Date _____

Print Name _____ Patient Date of Birth _____

Name of Credit Card Holder _____

Credit Card Holder's Signature _____

If you are signing this Credit Card Authorization as a parent, guardian, or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

❑ Parent ❑ Conservator ❑ Power of Attorney for Health Care
❑ Guardian ❑ Health Care Surrogate ❑ Executor / Administrator

Signature _____ Date _____

Name _____