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 a credit card is required to be on file prior to telehealth services being rendered. 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 ____________________