9550 Hickman Road, Suite 101
Clive, Iowa 50325
Phone: 515-758-8300
Fax: 515-758-8600

CREDIT CARD AUTHORIZATION

Name: _____

DOB: _____

I authorize Integrated Psychiatry PLLC to process my credit card as "Card on File" and charge in accordance with the agreed upon payment between the practice and me (e.g. one time charge, monthly payment plan, copayment, deductible, balance due to clinic). I understand this authorization will remain in effect until the expiration of the credit card account. Patient may revoke this form by submitting a written request to the medical practice.

Credit Card Number:_____

Expiration Date: _____

CCV: _____

Name on Card: _____

Zip Code:_____

Signature:_____ Date:_____