Credit Card Charge Authorization

Patient Name: _____

Charges: As per agreement for initial evaluation, TMS therapy, medication management, and/or incidental charges.

Credit Card Information:

Circle One: VISA / MASTERCARD / AMERICAN EXPRESS

Name on the face of the Credit Card: _____

16 Digit Credit Card Number: _____

Expiration Date: _____

CVV2 number: _____

Cardholder's ZIP Code: _____

By signing below, I am authorizing Maui Mind Care to place charges on the above noted credit card for the purpose of medical treatment. I have the legal authority to give such permission. I am aware charges will be placed on the appointment date(s), unless otherwise noted. I am also reminded that charges are placed for missed appointments, and for cancellations made within 24 hours of the scheduled appointment. I am aware that this information is privileged and will be kept confidential.

Signature: _____ **Date:** _____

Printed Name: _____