Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization is in effect until cancelled.

Date:_____
Patient Name:_____
Doctor:_____
Patient Phone Number:_____
Patient Email Address:_____
Patient Address:_____
Date of Birth:_____

Credit Card Information

Please be aware that a $3.00 flat rate service fee applies to all SQUARE transactions.

Card Type:____Mastercard ____Visa ____Discover ____AMEX ____Other
Cardholder Name (as shown on card):_____
Card Number:_____
Three Digit Code on Back of Card:_____
Expiration Date (mm/yy):_____
Cardholder Zip Code (from credit card billing address):_____

I, _____, authorize Midlands Psychiatric Services to charge my credit card above for agreed upon services. I understand that my information will be saved via SQUARE for future transactions on my account. *IF YOU DO NOT PROVIDE AT LEAST 24 HOURS NOTICE TO CANCEL YOUR APPOINTMENT, YOUR CARD WILL BE CHARGED A NO SHOW FEE.*

_____ _____
Patient Signature Date