RIVERVIEW
Community Mental Health Center

Credit Card Authorization Form for Therapy

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until it is cancelled in writing to your therapist.

I understand that I will be charged the amount of $40.00 for ALL missed therapy appointments that are canceled on the same day or less than 24 hours before the scheduled date of service.

A receipt for each payment will be provided to you and the charge will appear on your credit card or bank statement. You agree that no prior notification will be provided, and you agree to allow the card to be run on the day of the missed appointment.

Credit Card Information

Patient Name: _____ Phone Number: _____

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other

Card Number: _____

Expiration Date: _____ CVV Code: _____

Card ZIP Code (from credit card billing address): _____

I, _____, authorize Riverview Community Mental Health Center, LLC to charge my credit card above a fee of $40.00 for any missed therapy appointment. I understand that my information will be saved on file for any future missed appointment transactions on my account.

Patient Signature _____

Date _____