CREDIT CARD AUTHORIZATION

I hereby authorize Sugi Psychiatry and Wellness to keep my credit card and signature on file. I understand that this authorizes Sugi Psychiatry and Wellness to charge my credit card account for the balances of any outstanding amount for my account with Sugi Psychiatry and Wellness or other non-covered services received. This authorization will remain in force until Sugi Psychiatry and Wellness has received written notification from me of its termination in such time and in such manner as to afford Sugi Psychiatry and Wellness a reasonable opportunity to act on it and collect any remaining balances. In addition, I also understand that Sugi Psychiatry and Wellness will bill my credit card at the end of the business day for any missed appointment or if I cancel my appointment within the timeframe outlined in my signed Financial Policy. I further understand and I am aware that I am responsible for any fees associated with declined credit card charges.

Patient Name ______________________ Patient DOB ______________________

Credit Card Type: ☐ VISA ☐ Mastercard ☐ Discover ☐ AmEx

Card Holder's Name ______________________

Credit Card Number ______________________ Expiration Date ______________________

Security Code (3-digit code on back of card) ______________________

Credit Card Billing Address (the address where the credit card statement is mailed to) ______________________

Card Holder's Signature ______________________ Date ______________________