10395 Double R Blvd • Reno, NV 89521 | 775-507-2606 | www.sugipsychiatry.com

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 for applicable visit copays, as well as the balances of any outstanding amount for my account with Sugi Psychiatry and Wellness or other non-covered services received.** I also understand that Sugi Psychiatry and Wellness will charge my credit card at the end of the business day for any missed appointment or late cancellation as 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. 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.

_____ _____

Patient Name *Patient Date of Birth*

CREDIT CARD INFORMATION:

CREDIT CARD TYPE: ____ VISA ____ MC ____ DISCOVER ____ AMEX

_____ _____

Card Holder's Name (as it appears on credit card) *Expiration Date*

_____ _____

Card Number *Security Code (3 digit code on back of card)*

_____

Billing Address

_____ _____

Card Holder's Signature *Date*