ACHIEVE
PSYCHIATRIC WELLNESS CENTER
904-517-8900 or 855-PSY-WELL www.achievepsych.com

Credit Card Payment Authorization Form

Sign and complete this form to authorize ACHIEVE Psychiatric Wellness Center to make a debit to your credit card listed below. Your card will only be charged for the following: Co-pays, uncovered services, missed appointment fees.

By signing this form you give us permission to debit your account for the amount due on or after the indicated date. This is permission for any unpaid balance and does not provide authorization for any additional unrelated debits or credits to your account.

Please complete the information below:

I _____ authorize ACHIEVE Psychiatric Wellness Center to charge my credit card account
(full name)

indicated below for any unpaid balance plus transaction fees on or after receiving services.

This payment is for Psychiatry services received.

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Account Type: Visa ☐ MasterCard ☐ AMEX ☐ Discover ☐

Cardholder Name _____

Account Number _____

CVV _____

Expiration Date _____/_____

SIGNATURE _____ DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount of unpaid balances only, and is valid for one time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form and services provided.