CBC
Chicago Behavioral Clinic

Credit Card Authorization Form

Authorization for payment and Fees via Credit Card

I authorize the payment of fees for _____

(Patient's name)

to the Chicago Behavioral Clinic, LLC for services rendered. Your credit card will be charged when payment of balance in full is required.

Credit Card Information:

Name on Card:

Billing address:

City:

State:

Zip:

_____Visa _____MasterCard _____American Express _____Discover

Card Number:

Expiration Date: CVV:

Patient's Signature: _____

Date: _____

It is the responsibility of the client and the responsible party to notify the Chicago Behavioral Clinic if the credit card listed on this form is canceled or is no longer valid. If there are any issues with the credit card listed on this form, the responsible party will be notified so updated credit card information is kept on file for the patient.

www.chicagobehavioralclinic.com
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