BHC–BEHAVIORAL
HEALTH CONSULTANTS, INC

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us at 713-463-9449. This authorization will remain in effect until canceled.

Credit Card Information	
Card Type: ___Mastercard ___Visa ___ AMEX ___ Discover	
Cardholder Name (as shown on card):	
Card Number:+	
Expiration Date:	**CVN (Security Code):**
Card billing address:	
City:	**Zip code:**
Patient/Client Name (if different from cardholder):	

Authorized Amount Range: $10 (min) to $_____

Select all that applies:

- O one time $60.00 security deposit (refundable if appointment is canceled or rescheduled 24 hours in advance)
- O No show / late cancellation fee **($60.00)**
- O recurring charges for my visits, not to exceed authorized amount
- O any unpaid charges past 90 days from service date (this includes, but not limited to, OOP expense, copay/coinsurance, deductibles)
- O MISC (RX fee, Letter request fee, Medical record retrieval fee, Paperwork completion,Other--please specify _____
- O Payment plan: Total Amount Due: $_____
  Payment period: _____/_____/_____ through _____/_____/_____
  Payment schedule: _____ equal monthly installment of $_____ with the first payment due on _____/_____/_____, plus one final payment of approximately $_____ due on _____/_____/_____

I, _____authorize BHC-Behavioral Health Consultants, Inc. to charge my credit card above for agreed upon transactions. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Patient/Client Signature (Guardian if minor) **Date**

Please return this form via fax 713.463.7181 or email frontdesk@bhchouston.com Attn: Billing Dept