Uptown Psych
Behavioral INC.

**Credit Card On File Form**

*We require keeping your credit or debit card on file as a convenient method of payment when authorized.*

_____ I authorize Uptown Psychiatry Specialists to charge my credit/debit card for any late fees as outlined in the 'patient financial responsibility' form.

______I authorize Uptown Psychiatry Specialists to charge my credit/debit card for services not paid by my insurance company within 90 days from services rendered, including copays/deductibles/coinsurance.

_____ I will inform Uptown Psychiatry if my credit card information or expiration date changes.

**Visa** **MasterCard** **Amex** **Discover**

**Card Number** ________________________________________

**Expiration Date** ________________________________________

**CVV Code** ________________________________________

**Name on Card** ________________________________________

**Address** ________________________________________

**Zip Code** ________________________________________

**I understand that this form is valid without expiration unless I cancel this authorization by notice in writing submitted to Uptown Psychiatry.**