



Selman Behavior Solutions

*Finding Solutions * Creating Change*

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CREDIT CARD AUTHORIZATION FORM

Date: _____

I understand that I am responsible for informing the office of any card renewals or account changes. I understand that this form is valid unless I submit a request to Selman Behavior Solutions in writing to cancel the authorization.

By signing this form, I authorize Selman Behavior Solutions to charge the following credit card at the time services are rendered. Your credit card information will be kept in a secure location and our administrative team will charge your card at the time services are rendered. In some cases, a payment plan may be discussed and agreed upon. Your account will be charged according to the plan.

I understand that if an appointment is cancelled, missed, or rescheduled with less than 24 hours notice, I am required to pay the full cost of the appointment. My card will be charged under these conditions.

Patient Name: _____ DOB: _____

Credit Card Number _____

Expiration Date ____/____

CVV Code _____

Cardholder Name _____ Signature _____

Billing Address _____

City _____ State _____ Zip Code _____