gulfcoast BEHAVIORAL HEALTH
1938 SOULE ROAD, CLEARWATER, FL 33759 Ph. (727) 726-7442 F. (727) 288-1111 www.gulfcoastbh.com

CREDIT CARD AUTHORIZATION FORM

Patient Name:_____DOB: _____

Phone:_____Client Acct #: _____

○ VISA ○ MasterCard ○ DISCOVER

Credit Card Number _____-_____-_____-_____

Expiration Date:_____/_____

CVV Code: _____

Cardholder Name: _____

Billing Address: _____

_____ _____ _____
City State Zip Code

Phone Number: (_____)_____- _____

I,_____(Cardholder), authorize Gulfcoast Behavioral Health to charge my credit card for balances of charges for services rendered that were not paid by or covered by insurance within 90 days, as well as any balance resulting from missing appointments and/or late cancellations.

This agreement shall remain in effect until the Office is notified in writing by the Cardholder to cease all charges.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Witness