PRA Credit Card Authorization

In order to ensure payment is processed at time of service, PRA allows for credit card authorization to be held securely to be kept on file. Please complete the information below so you can have session fees processed promptly to avoid future statement billing fees.

Patient Name: _____ Clinician's Name: _____ Account No: _____

I, _____authorize PRA Behavioral LLC to charge my credit card for the ***initialed*** reasons below:

_____ **(Initials)** Per session (if not paid by other means) – For copays, deductibles and other charges due at time of visit.

_____ **(Initials)** Balances on Account – Balances on your account not paid by insurance within 60 days may be charged. PRA will notify you of the amount to be charged prior to charging your credit card.

_____ **(Initials)** Missed Sessions – Charge for missed sessions will automatically be charged if failure to cancel within 24 hours of your scheduled appointment. You will be informed when this charge has been made.

I authorize PRA Behavioral LLC to keep my signature safely on file for future charges authorized by me as indicated by my initials above. I authorize email confirmation for receipts if checked below. I understand that this form is valid unless I cancel the authorization by written format.

Receipt: ☐ Give to Therapist ☐ Shred ☐ Keep on file ☐ Mail to: Client or Cardholder

☐ E-Mail through Cardpoint to: _____
Email Address

_____ _____ _____
Cardholder Signature Initials Date

☐ Visa ☐ Mastercard ☐ HSA Card ☐ Discover ☐ AMEX ☐ Check Card ☐ Other _____

Credit Card #: _____ V-Code: _____

Expiration Date: _____/_____ Zip: _____

Cardholder Name, as it as it appears on the card: _____

Cardholder Address: _____

City:_____, State: _____ **Zip** _____

Phone Number for Credit Card Holder – (_____) _____ - _____

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