PRA Credit Card Authorization

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

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

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

_____ 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.

_____ 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 to keep my signature on file for future charges authorized by me as indicated above. I understand that this form is valid unless I cancel the authorization through written notice.

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

_____ _____ _____

Cardholder Signature Initials Date

☐ Visa ☐ MasterCard ☐ HSA Card ☒ Discover ☐ Check Card ☐ Other _____

Credit Card #: _____-_____-_____-_____ V-Code: _____ Exp. Date:_____ Zip: _____

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

Cardholder Address: _____, City_____, State _____, **Zip** _____

List of charges and dates of service on back of this form

8/13