HOPE419 PSYCHIATRY & COUNSELING, LLC

Credit Card Authorization Form

Complete in person. This form authorizes payment processing through Hope419 approved secure payment systems.

PATIENT / CARDHOLDER INFORMATION

Patient Name: _____	**Date of Birth:** _____ / _____ / _____
Cardholder Name: _____	**Phone:** _____
Email for Receipt: _____	**Text Receipt Number:** _____

AUTHORIZATION TYPE

[ ] ONE-TIME CHARGE only in the amount of $_____ [ ] RECURRING / CARD-ON-FILE AUTHORIZATION

Authorization: I authorize Hope419 to charge the payment method I provide through Hope419 approved secure payment systems, including Tebra and/or Stripe, for patient-responsible charges associated with my care, including copays, coinsurance, deductibles, account balances, and applicable fees. For a one-time charge, I authorize only the amount written above. For recurring/card-on-file authorization, I authorize charges at the time of service or when balances become due, including adjustments to my account as needed.

Patient agreement: I agree that charged amounts will be applied to my account balance to offset charges for services and fees. I will make a good faith effort to resolve any billing concern directly with Hope419 before disputing charges with my card company. I guarantee that I am the legal cardholder or am legally authorized to use this card. I understand that I must contact Hope419 in advance to cancel or change this authorization for future visits.

PAYMENT PROCESSING NOTICE

Hope419 processes credit card payments through its approved secure payment systems, including Tebra and/or Stripe. I understand that my card information will be entered, stored, and processed only through Hope419 approved secure payment system and will not be stored on the uploaded copy of this form.

PAYMENT METHOD INFORMATION FOR EHR COPY

Security note: Do not record or upload the full card number or CVC/CVV on this copy. Full card details should be entered only in Tebra, Stripe, or another Hope419 approved secure payment system.

Card Type: [ ] Visa [ ] Mastercard [ ] AmEx [ ] Discover	**Last 4 Digits Only:** ____ ____ ____ ____
Expiration Month/Year: _____ / _____	**Billing ZIP:** _____
CVC/CVV: [ ] Verified for authorization only - not stored	**Processed Through:** [ ] Tebra [ ] Stripe [ ] Other: _____
Date Entered/Verified: ____ / ____ / _____	**Staff Initials:** _____

ELECTRONIC / WRITTEN SIGNATURE

By signing below, I affirm, acknowledge, and agree that this is my valid and legally binding authorization and signature.

Signature: _____	**Date Signed:** _____ / _____ / _____
Printed Name of Authorized Card User: _____	**Relationship to Patient, if not patient:** _____

OFFICE USE / UPLOAD CHECKLIST

[ ] Payment method entered/updated in Tebra or Stripe	[ ] EHR copy uploaded
[ ] Any temporary card worksheet destroyed/shredded after processing	[ ] Receipt preference confirmed
Staff Initials: _____	**Date:** _____ / _____ / _____