Solutions Outpatient Services

CREDIT CARD AUTHORIZATION (VISA & MASTER CARD ONLY)

Please fax a copy of the front and back of the actual credit card. The signature on the back of the card must match the signature on this authorization.

Please write legibly and with a black pen.

Cardholder Name	
Billing Address for Cardholder	
Cardholder Phone Number	
Cardholder Fax Number	
Credit Card Number	
Expiration Date	
Type of Credit Card	

CREDIT CARD WILL BE PRE-AUTHORIZED

I have authorized Solutions Outpatient Services to keep my signature on file and to charge my Credit Card for:

- ❑ **Full payment $_____ for this visit only.**
  - ❑ **Balance of charges not paid by insurance within 90 days and not to exceed $_____ for this visit only.**

- ❑ **Recurring charges of $_____**
  Every _____ from _____ to _____
  - ❑ **Balance of charges not paid by insurance within 90 days and not to exceed $_____ for on going treatment.**

- ❑ **Other (Specify) _____**

- ❑ **I assign my insurance benefits to Solutions Outpatient Services.**
- ❑ **I Do Not assign my insurance benefits to Solutions Outpatient Services.**

By signing below, I authorize Solutions Outpatient Services utilization of the above credit card for _____.

Client's Name

_____ _____

Signature of Card Holder **Date**