HEALING MINDS

Psychiatric-Mental Health Nurse Practitioner

Credit Card Authorization Form

I authorize Healing Minds to securely store my credit/debit card information and to charge my card for:
- No-show or late cancellation fees ($90)
- Copayments, deductibles, or any remaining balance not covered by insurance

I understand that my card information will be kept securely and may only be used for the purposes listed above.

Card Information

Cardholder Name: _____

Card Number (last 4 digits acceptable): _____

Expiration Date (MM/YY): _____

Billing ZIP Code: _____

Patient Information

Full Legal Name: _____

Date of Birth (MM/DD/YYYY): _____

Phone Number: _____

Your typed signature authorizes the use of your card according to the terms above.

Signature (Typed Name): _____

Date: _____