



## Credit Card Payment Consent Form



**Patient Name** \_\_\_\_\_  
*Print Last First Middle Initial*

Name on Card if different \_\_\_\_\_

**I authorize Agor Behavioral Health Services Inc. and ProfessionalCharges.com, to charge my credit/debit card for professional services as follows:**

- Initial*  
\_\_\_\_\_ This visit only, for the amount of \$ \_\_\_\_\_ .
- \_\_\_\_\_ All visits in the next 12 months, beginning \_\_\_\_ / \_\_\_\_ / \_\_\_\_,  
not to exceed \$ \_\_\_\_\_ total.
- \_\_\_\_\_ Recurring charges, date(s) of service \_\_\_\_ / \_\_\_\_ / \_\_\_\_ to  
\_\_\_\_ / \_\_\_\_ / \_\_\_\_, not to exceed \$ \_\_\_\_\_,  
\_\_\_\_ monthly, \_\_\_\_ semimonthly, \_\_\_\_ weekly, \_\_\_\_ per visit.
- \_\_\_\_\_ **To charge my card for the balance of fees not paid by my insurance company within 90 days, as indicated above.**

Type of Card:  Visa,  MasterCard,  Discover.

Credit Card Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_, CVV Number \_\_\_\_\_  
A 3-digit number in reverse italics on the **back** of the credit card

Expiration Date \_\_\_\_\_

Card Holder's Billing Address for Credit Card Statements

\_\_\_\_\_  
*Street City State Zip*

**Card Holder Signature** \_\_\_\_\_, Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

*Charges will appear on your credit card statement as an abbreviation of*  
**ProfessionalCharges.com.**