



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 ____ / ____ / ____

ProfessionalCharges.com.