alo·ha psych
ASSOCIATES, INC.

CREDIT CARD PAYMENT CONSENT FORM

Patient Name _____
Print Last *First* *Middle Initial*

Name on Card if different _____

I authorize Alo.ha Psych Associates, Inc. and Chase Paymenttech **to charge my credit/debit card for professional services as follows:**

Initial

_____ **To charge my card for the balance of fees not paid by my insurance company within 60 days. To immediately charge my card for un-collected co-pays and no show/or late cancel fees.**

Initial

_____ **To charge my card for $_____ to cover retainer or fee for service.**

Type of Card: □ Visa, □ MasterCard, □ Discover □ American Express

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 ____ /_____ /____

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transforming behavioral, emotional, physical and social health