NeuroPsychiatry Center - Ravi Kant, MD, P.C.
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Tel. # 412-220-7323 Fax # 412-220-7325

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us in writing. This authorization will remain in effect until canceled.

Credit Card Information
Card Type: □ MasterCard □ VISA □ Discover □ AMEX □ Other_____
Cardholder Name (as shown on card): _____
Credit Card Number: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____
CVV (3 digits on the back of the card): _____

I, _____ authorize NeuroPsychiatry Center to charge my credit card listed above for services provided. This can include self-pay fees, co-payments, deductible, and other charges such as no-show fees, and services not covered under my insurance. I understand my credit card will not be charged more than $300 at one time. I understand that my information will be saved on file for future transactions on my account. I am responsible for keeping this information updated in a timely manner. This authorization will apply to any credit card updates in the future. I am aware that NeuroPsychiatry Center will be unable to notify me before processing this card on file and that my card may be charged at any time at the discretion of NeuroPsychiatry Center for the reasons listed above. These circumstances DO NOT apply to medical assistance recipients.

_____ _____

Patient/Guardian Signature Date