4300 Weaver Parkway, Suite 100-A
Warrenville, IL 60555
Phone: (630) 416-8289 Fax: (630) 416-8306

Credit Card on File

I authorize Conventions Psychiatry and Counseling to keep the following credit card(s) information on file.

Primary Card Account

____
Name on credit card (Exactly as printed)

____

____
Billing Address

____
Credit Card Number

____
Exp. Date CVV2#

____
Signature Date

Secondary Card Account

____
Name on credit card (Exactly as printed)

____

____
Billing Address

____
Credit Card Number

____
Exp. Date CVV2#

____
Signature Date

I authorize Conventions Psychiatry and Counseling to charge my credit card on file for balances indicated below:

Co-payments
Coinsurance
Deductible
Office Fees- Not limited to: no-show fee, cancellation fee, prescription fee, etc.

Since the payment amount may vary, I will be notified of the amount and date of the transaction. This authorization is valid until I provide you with written cancellation.

____
Patient Name (Please Print)

____
Patient/Legal Guardian Signature Date