AUTHORIZATION FOR AUTOMATED BILL PAYMENT PROGRAM

Auto draft by Visa/Mastercard

Please return this form to: Advanced Medical Psychiatric Services, 3409 Calloway Drive, Suite 601, Bakersfield, CA 93312

Patient Name:

Address:

Primary Telephone Number:

Email:

☐ **I, _____, authorize Advanced Medical Psychiatric Services to obtain payment by telephone for my schedule appointment.** (By choosing this option, credit card information is not required but, please, still sign and date form.)

Visa/Mastercard Draft

Visa/Mastercard Number: _____ Security Code: _____

Name on Card: _____ Expiration Date: _____
(Exactly as it appears on card)

Mailing address your card statements are received:

_____

_____

City State Zip Code

I, _____, authorize Advanced Medical Psychiatric Services to obtain an automatic payment on my account in the amount of $_____.

____ on the day of my scheduled or $ 25 if I fail to cancel my appointment in less than 24 hours notice.

____ on the ____ day of every month until my balance is cleared.

_____

Signature (REQUIRED) **Date**