Credit Card Authorization Form

Omega Mental Wellness

This form authorizes Omega Mental Wellness to charge the credit card listed below for services rendered, including but not limited to: copayments, missed appointments, late cancellations, and outstanding balances.

Please fill out the following information. This form will be stored securely and used only with your permission or as per our payment policy.

Patient Full Name: _____

Patient Date of Birth: _____

Phone Number: _____

Email: _____

Cardholder Name (as shown on card): _____

Billing Address: _____

City: _____ State: _____ ZIP: _____

Credit Card Number: _____

Expiration Date (MM/YY): _____ CVV: _____

Authorization:

[ ] I authorize Omega Mental Wellness to keep my card information on file and to charge this card for recurring appointments, missed appointments, late cancellations, and any balances due.

This authorization is valid until I provide written notice to revoke it.

I certify that I am an authorized user of this card and will not dispute charges that align with this agreement.

Signature: _____ Date: _____

Note: For your security, Omega Mental Wellness adheres to HIPAA and PCI compliance standards. We recommend submitting this form through our secure patient portal or in person. Do not email this form unless encrypted and approved.