MENTAL HEALTH SOLUTIONS S.C.

7633 Ganser Way, Suite 204
Madison, WI 53719
Phone: (608) 829-1800
Fax: (608) 829-1885

Please complete all fields
This authorization will remain in effect until cancelled
You may cancel this authorization at any time by contacting us
If you cannot pay your bill on time, please contact us to set up a payment plan

SECURE PAYMENT STORAGE AND USE AUTHORIZATION

Patient Information

Name:	Date of Birth:
Address:	Phone:

Card Information

Name on Card:	Last 4 Digits on Card:
Billing Address: □ Check if same as above	Phone: □ Check if same as above
Type of Card: □ Credit □ Debit □ HRA/HSA**	

**HRA/HSA Cards cannot be used to pay Late Cancel or No Show Fees

I hereby authorize and request **Mental Health Solutions, S.C.** to charge the stored card at the time of statement processing (between the 6th and 10th of every month) for the following fees:

□ Co-pays only □ Entire balance due at time of statement

I understand that my information will be securely saved for future transactions on my account

Printed Name of Card Holder:_____

Signature of Card Holder:_____ Date:_____

FOR OFFICE USE ONLY

Patient Valant Identifier_____ **Staff Initials**_____