N C
B M
Newport Center For
Behavioral Medicine

1101 Dove Street, Suite 250
Newport Beach, CA 92660

CREDIT CARD AUTHORIZATION

Please complete the following information.

I, _____, am authorizing Newport Center for
(Print Name)
Behavioral Medicine to charge my credit card in the event that I fail to show for a scheduled appointment, or do not give notification of my inability to attend a scheduled appointment at least **48 business hours** in advance.

Furthermore, for outstanding payments equal to or greater than 60 days, I authorize Newport Center for Behavioral Medicine to charge my credit card for the full amount due. I will not dispute charges for sessions I have received or that I have not cancelled less than **48 business hours** in advance.

I further authorize Newport Center for Behavioral Medicine to disclose information about my attendance/ cancellation to my credit card company if I dispute a charge.

Card Type (circle one): Visa MasterCard Security Code: _____

Card #: _____ Expiration Date: _____

Name as Printed on Card: _____

Billing Address: _____
(Street, City, State, & Zip)

Date: _____

_____ _____

Signature of Patient /Parent/Guardian **Print Name**

This form will be securely stored in your clinical file and may be updated upon request at any time. Please note, your credit card will not be charged unless the following conditions apply:
no-show for a scheduled appointment, cancellation less than 48 business hours in advance, or participation in treatment (eg. appointment or phone session) without payment rendered.