Please complete the information below to authorize co-pays and payments after insurance.

For your convenience, we accept Visa, Mastercard and Discover.

VISA ☐ MASTERCARD ☐ DISCOVER ☐

Cardholder Name (as shown on card) ____

Account Number ____

Expiration Date (mm/yy) _____________________ 3 Digit Security Code _____________________

Co-Pay Amount (if applicable) _________________

House Number ___________________ Zip Code ___________________

I _____________________________________ authorize PsychOne P.C. to charge my credit card
(please print name)
listed above for agreed upon charges. I understand that my information will be saved for future transactions on my account.

____ ___________________________
Cardholder Signature Date