ELECTRONIC PAYMENT AUTHORIZATION

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time. I ___________________________________ give permission to have my card charged if I fail to make a payment or miss an appointment. You will be notified by Elana prior to any charge.

CLIENT INFORMATION:

Client Name:_______________________________________ **DOB:**___________________________

Responsible Billing Party Name (as shown on Credit Card/Account)**:**_________________________________

Billing Address (as registered with Credit Card Company)**:**

____

____

Mobile Number:________________________ **Home Phone Number:**_________________________

Email Address:____

ACCOUNT INFORMATION:

Card Type (Visa, MasterCard, & Debit):_________________________

Credit Card #:____

Expiration Date:________________________

Three Digit Security Code (Located on Back of Card)**:**____________________

____ _________________________

Client Signature **Date**

Please return this form to your provider

7421 Beverly Blvd., Suite 2, Los Angeles, CA 90036

T: 888.851.2666 | F: 323.951.1119 | info@recoveryhelpnow.com | www.recoveryhelpnow.com