ADVANCED PSYCHIATRIC GROUP
APG RESEARCH, LLC.

MAIN OFFICE
736 N MAGNOLIA AVE . ORLANDO FL . 32803
407.423.7149
407.422.0470
WWW.APGHEALTH.COM

APG RESEARCH, LLC.
721 N MAGNOLIA AVE . ORLANDO FL . 32803
407.422.0470

CREDIT CARD PAYMENT CONSENT FORM

PATIENT NAME: ____
PRINT LAST FIRST MIDDLE INITIAL

FULL NAME ON CARD: ____

CARD TYPE: □ AMEX □ MC □ VISA □ DISC

CARD NUMBER: ______________________________________

EXPIRATION: ____ / 20____

CVV: _____

CARD HOLDER BILLING ADDRESS: ____
STREET

____
STREET

____
CITY

____
STATE

____
ZIP CODE

I, ____________________________, hereby authorize:

□ for charges of $__________ for a missed or last minute canceled Initital Appointment (Canceled/missed within 48 business hours of scheduled appointment)

□ for charges of $__________ for professional services

If I have questions about these charges, I agree to contact Advanced Psychiatric Group, P.A. via email (info@apghealth.com). I agree that I will not pursue a refund directly through my credit/debit card company, bank, or financial institution. If any of my actions yield a chargeback for any reason, I agree to pay any and all penatly fee(s) incurred by my provider.

ACKNOWLEDGEMENT

I have read and understand the Credit Card Payment Consent form listed above.
A photocopy or facsimile of this signature is as valid as the original.

______________________________________ ____________________
CARD HOLDER SIGNATURE DATE

ACCEPTED