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 authorize Advanced Psychiatric Group, PA to initiate recurring charges to my credit card indicated above for the total amount due each office visit. I also authorize charges for any additional related services or fees that I may incur. Charges to my account may vary. I will be provided notice if the charges exceed $_____.

I authorize Advanced Psychiatric Group, PA to keep my card on file.

I understand that I may cancel my recurring charges upon written notice allowing thirty (30) days time for action on my cancellation notice.

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