EASY PAY CONSENT

I authorize Crossroads Counseling Centers, Inc. to charge my credit, debit, or Health Savings Account card at the time of service for copayments, deductibles, co-insurance, late cancellations and no-show appointments as they occur.

Please indicate if you would like Crossroads Counseling Centers to mail a monthly statement indicating charges incurred on your card.

☐ Yes ☐ No

By marking "No" your card will still be debited for any applicable charges mentioned above; however a statement will ***not*** be mailed unless requested. A statement may be requested through our business office at any time during business hours.

Cardholder Information

Name: ____

Address:____

City: _____________________________ State: ____________________ Zip: ____________________

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Card Number: ____

Expiration Date (MO/YR): __________________ CVV: _________________

Cardholder Signature: _______________________________________ Date: _____________________