Regent Mental Health Group, S.C.

700 Rayovac Dr., Ste 103, Madison, WI, 53711

AUTOMATIC PAYMENT PLAN

I authorize **Regent Mental Health Group, S.C.** to automatically charge my credit card (*Visa, Mastercard, Discover, Am. Express)* listed below for items listed on the monthly statement for:

_____ _____

Client Name ***Date of Birth***

This authorization is to remain in effect until I cancel in writing.

The **Payment Plan** I prefer to be on is:

- ☐ Pay the entire amount after each visit
- ☐ Pay the entire amount at the end of each month
- ☐ Monthly Payment Plan:
  A monthly payment of $ _____ per month to be processed on the ____ day of each month.*
- ☐ A one-time payment of $ _____

* If this date falls on a weekend, payment will be processed the following Monday

CARD TYPE	CARD NUMBER	EXPIRATION DATE	CVV CODE	EFFECTIVE DATE
Mastercard				
Visa				
Discover				
American Express				

Name as it appears on the card (please print): _____

Authorized Signature: _____ Date:_____

Home Telephone #:_____ Work Telephone #: _____

Home Address: _____

- ☐ **I authorize a minimum charge of $ _____ and a maximum charge of $_____**
- ☐ **Not applicable**
- ☐ **No minimum or maximum limit**

For Office Use Only

_____ _____ _____