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*
- ☐ Decline Automatic Payment

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

***If you decline to use AutoPay, please type 'N/A' in the Card sections.**

CARD TYPE	CARD NUMBER	EXPIRATION DATE	CVV CODE
Mastercard			
Visa			
Discover			
Am. Express			

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

Home Telephone #: _____

Work Telephone #: _____

Home Address/City/State/Zip Code: _____

Please check one of the options below:

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

Signature: _____

Date: MM-DD-YYYY _____