Rebecca Farinas, MD, LLC
Diplomat American Board
Psychiatry & Neurology

7545 Centurion Parkway #302, Jacksonville, FL 32256, phone (904) 997-7776, facsimile (904) 997-7057

Credit Card Authorization Form

Name of Patient: _____DOB: _____

First Name (as it appears on credit card): _____

Last Name (as it appears on credit card): _____

Relationship to Patient: _____

Credit Card Type: Please Circle Visa MasterCard

HSA Card: Please Circle Yes No (If Yes, please provide Secondary card information)

Credit Card Number: _____ Secondary Card Number _____

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City, State _____

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I authorize Rebecca Farinas, M.D., LLC to charge this credit/debit/HSA debit card for any and all co-payments, patient responsibility portions of my insurance explanations of benefits (if applicable), fee for the completion of any forms and/or letters I request, lost prescriptions, prescription refills, and missed/no-show or late appointment fees.

I certify that I am an authorized signer on this card and that the credit card number and signature below are the same as those on file with the credit card issuer.

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