

Credit Card Authorization for
Third Party Appointment Scheduling

I, _____ hereby request that
(Name of Responsible Party)

Santa Barbara Behavioral Health (SBBH) make an exception to the usual policy to only schedule appointments directly with patients or their legal guardian. In consideration of this exception, I accept financial responsibility for the full fee for the scheduled service and hereby authorize Santa Barbara Behavioral Health to charge my credit card the full amount of that professional service if the appointment is missed or cancelled with less than 24 business hours' notice.

Patient name

Patient relationship to cardholder

Appointment date

Provider name

Type of Card (Circle one):

Visa

MasterCard

Discover

Credit Card Number:

Expiration Date:

Name of Cardholder:

Credit Card billing address:

Zip

Security code (back of card):

Authorized Signature of Cardholder

Date:
