Child & Adolescent
Psychiatric Services of Maine
Peter Y. Kang, DO
Board Certified Child and Adolescent Psychiatrist

# Credit/Bank/FSA/HSA Card Recurring Payment Authorization Form

Patient Name: _____ DOB: _____

| **Credit Card Information** | ☐ New | ☐ Update |
|---|---|---|
| Card Type: | ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX | |
| | ☐ Other: _____ | |

Cardholder Name (as shown on card): _____

Card Number: _____

Expiration Date (mm/yy): _____/_____ Security Code (CVV #): _____

Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize *Child & Adolescent Psychiatric Services of Maine* to charge the account above for agreed upon purposes. I understand that the above information will be saved for future transactions and that there is some inherent risk to saving financial information. I agree to not hold *Child & Adolescent Psychiatric Services of Maine* responsible for fraud or theft related to the saving of this information. This Authorization will remain in effect until it is canceled in writing.

☐ By checking this box, I enable *Child & Adolescent Psychiatric Services of Maine* to charge the account for fees and other charges as they accrue.

SIGNATURE _____ DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify *Child & Adolescent Psychiatric Services of Maine* in writing of any changes in my account information or termination of this authorization. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I certify that I am an authorized user of this credit card and will not dispute transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

7 Oak Hill Terrace, Suite 218, Scarborough, ME 04074

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