Patient Name (Please print) : _____

I _____, give St. Louis Behavioral Medicine Institute permission to use my credit card (which will be kept on file), for any balances incurred during treatment at St. Louis Behavioral Medicine Institute.

This includes all patient balances including copays, deductibles and coinsurance as well as missed sessions and telehealth sessions completed.

If I have my card on file for the Intensive Outpatient Program; my card will be charged on Mondays (for the prior week) and then the last day of the month or upon discharge.

CCARD#_____

EXP DATE _____ LAST 3 DIGITS ON BACK OF CARD _____

_____ _____

Responsible Party (Please Print your name) Date

_____ _____

Responsible Party Signature SLBMI Representative Signature