Central Jersey Behavioral Health, LLC
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Credit/Debit (HAS/FSA) Card Payment Authorization Form

Sign and complete this form to authorize Central Jersey Behavioral Health, LLC to make a debit to your credit card listed below.

By signing this form you give us permission to debit your account. This permission is/are for single/multiple transactions, and does provide authorization for any additional related debits or credits to your account.

Please complete the information below:

I _____ authorize Central Jersey Behavioral Health, LLC to
(Full name)
charge my credit/debit /HSA/FSA to pay for the service/s rendered to me or the party/ies under my insurance plan.

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ Discover

Cardholder's Name _____

Account Number _____

Expiration Date _____

CVV2 (3 digit number on back of Visa/MC) _____

******* Please be noted that for every transaction made on your account, our office will be mailing receipt of the transaction together with the statement of your account. We will include the date/s of service to which we applied your payment.**

SIGNATURE _____ DATE _____