Behavioral Health Clinic

IN PERSON • ONLINE

www.wibehavioralhealth.com

Credit Card on File

Client's Name: _____ DOB: _____

Card Type (check one): ☐Visa ☐MasterCard ☐Discover ☐American Express

Card #: _____ Exp. Date: _____ CID:_____

Name Printed on Card: _____ Billing Zip Code: _____

Co-payments and deductibles are due, no earlier than, two business days prior and no later than, two business day after your scheduled appointment.

** Please note that by signing your signature, you are giving permission for Behavioral Health Clinic to charge your credit card **

Signature of Card Holder: _____

Instructions:

In order to keep your credit card information secure and confidential. Please **mail** this form back to our office.

Wausau: 630 S. 36th Avenue

Wausau, WI 54401

Stevens Point: 2417 Post Road

Stevens Point, WI 54481