Regent Mental Health Group, S.C.

700 Rayovac Dr., Ste 103; Madison, WI, 53711

AUTOMATIC PAYMENT PLAN

I authorize **Regent Mental Health Group, S.C.** to automatically charge my credit card (*Visa, Mastercard, Discover, Am. Express)* listed below for my patient account balance:

_____ _____

Client Name Date of Birth

This authorization is to remain in effect until I cancel in writing or by speaking to the billing department.

The **Payment Plan** I prefer to be on is:

- ☐ Pay the entire amount at the beginning of each month
- ☐ Monthly Payment Plan of $_____
- ☐ No maximum limit
- ☐ Maximum charge of $_____
- ☐ Decline Automatic Payment

- If the date falls on a weekend, payment may be processed on the following business day

Card Type	**Card Number**	**Expiration Date**	**CVV Code**
Mastercard			
Visa			
Discover			
American Express			

Name as it appears on the card (please print) _____

Home Telephone # _____ Work Telephone # _____

Home Address _____

Authorized Signature _____ Date _____