409 Plymouth Road, Suite 250, Plymouth, MI 48170
2040 Grand River Annex, Ste. 300, Brighton, MI 48114
Phone: 734-416-9098, Fax: 734-416-0158
Email: office@mccaskillfamilyservices.com

Credit Card Payment Authorization Form and Patient Portal Email

Please fill in all areas completely and sign and date the bottom.

Type of card (check one): _____ MasterCard _____ VISA _____ AMEX _____ Discover
Is this a Debit Card? ___ Y ___N
Is this an HSA/FSA or Flexible Spending Account card? ___Y ___N

Name of Patient:_____

Name on the card (if different from patient): _____

Billing address of cardholder:_____

_____

Credit card number: _____CVC (3 digit code): _____

Expiration date: _____

I, _____, authorize McCaskill Family Services to charge the credit card indicated above. I understand that unless I notify my clinician otherwise, my current account balance will be charged to this credit card after each session.

Patient's Signature:_____
(Date)

Credit Card Holder's Signature (** if different than Patient)

_____ _____
(Date)

RECEIPTS: Please clearly print email address so that we may send you a link to your patient portal:

Email: _____