AUTHORIZATION TO BILL CREDIT CARD ON FILE

Patient Name: _____

Cardholder Name: _____

By signing this form, I authorize LifeStance Health to charge the credit/debit card provided (the "Card") for all outstanding balances, including, but not limited to, co-payment and co-insurance amounts, self-pay fee schedule amounts, no-show/cancellation fees, other administrative fees, and any balance remaining after insurance reimbursement relating to services provided to the patient. I understand that it is my responsibility to ensure that the information for the Card on file is current at the time of service, as necessary, and that if payment is declined, LifeStance Health may decline to provide new services until payment is received. I certify that I am an authorized signer for the Card with all necessary rights to authorize the charges.

Date: _____

Signature:

_____

Printed Name of Signer: _____

Relationship of Signer to Patient, if applicable: _____