Crasmere Psychiatric Services, PC
38 Winthrop Pl
Staten Island, NY 10314
P: (718) 727-7077
F: (718) 727-7673

Patient Name: _____

Signature of Patient or Responsible Party: _____

Relationship: _____

Date: _____

I, _____, hereby authorize **Crasmere Psychiatric Services, PC** to charge my credit/debit card listed below for payment of my **copay, deductible, or out-of-pocket (OOP) expenses**. I understand that this information will be securely stored and may be used for future transactions related to my account.

Credit Card Number: _____

Expiration Date: _____/_____

CVV Number: _____

Cardholder Name: _____

Signature: _____

Relation to Patient: _____

If you would like to keep this card on file for future use, please check off the box below.

☐ Yes, please keep this card on file for future payments. Thank you!