Diligence Behavioral and Medical
Integrated Healthcare, a Professional
Nursing Corporation (Diligence Care Plus)

255 N. D Street, Suite 400
San Bernardino, CA 92401
Phone: 909-276-1198: Fax 909-206-0636

Credit/Debit Card Payment Consent Form

Financially Responsible Party Name: _____
First MI Last

Name on Card if different _____

I authorize Diligence Behavioral and Medical Integrated Healthcare, a Professional Nursing Corporation, dba Diligence Care Plus, to charge my card for professional services as follows:

Please Initial: _____

Any agreed-on session or service that is not paid for at the time service is rendered, unless other arrangements have been made for payment or I have a dispute concerning the service or payment for that service. No debits will be processed on my card until the dispute is resolved. I have been informed that all information provided here will never be shared with any other parties, and that it will be stored and transmitted according to strict encryption protocols and meet all federal HIPAA requirements for privacy.

Type of Card:

☐ VISA ☐ MasterCard ☐ Discover ☐ Amex

Card Number _____ - _____ - _____ - _____

CSC/Security Code# _____

Exp. Date _____

Card Holder's Billing Address for Monthly Card Statements:

_____

Street City State Zip

Card Holder Signature _____ Date ____ /____ /____

*If I have questions about these charges, I agree to first contact my provider (Diligence Care Plus). I agree that I will not pursue a refund directly through my credit/debit card company, bank, or financial institution. If any of my actions yield a chargeback for any reason, I agree to pay any and all penalty fee(s) incurred by my provider. Please note that to be considered a valid card an HSA card must be tied to a funded account.