the Summit Center

3033 W. Jefferson St.
Suite 107
Joliet, IL 60435
Telephone: 815-773-0772
Fax: 815-773-0771

1801 North Mill Street
Suite J
Naperville, IL 60563
Telephone: 815-773-0772
Fax: 815-773-0771

Credit Card Authorization

For internal use only.

I, ______________________________________, authorize The Summit Center to keep my signature on file and to charge my credit card listed below for:

All patient balances for services rendered once the claim has been processed by my insurance company. I understand that SCMH will charge my card for any outstanding balances, including late cancellation and no-show fees when assigned, without additional authorization. I also understand that there will be a 3% charge on any credit card transactions.

I certify that the below information is true and accurate and that I am an authorized user on the credit/debit card below.

Recurring charges for services rendered for the following family members:

Patient Name: ____ DOB: __________________
Patient Name: ____ DOB: __________________
Patient Name: ____ DOB: __________________
Patient Name: ____ DOB: __________________

**We do not accept American Express

Billing Address:____City: ________________________ State: _______ Zip: ____________

Credit Card Number: ____ Expiration Date: _______________

❌ Cardholder Signature: ______________________________________ Date: ____________ Cardholder contact number: ____________________