Collaborative
Counseling & Psychiatry

# Credit Card Authorization Form

Card Holder's Name: _____
(Exactly as it appears on the credit card)

Client's Name: _____

Card Type (circle one): VISA MC AMEX DISCOVER

Card Number: _____ Expiration: _____

CVV Code (3/4 digits only): _____

Billing Address: _____

_____

Card Holder's Phone Number: _____

I authorize the purchase of services from Collaborative Counseling & Psychiatry, LLC using this Credit Card Authorization Form. I understand that Collaborative Counseling & Psychiatry, LLC may charge my card at any time for services rendered and for the subsequent outstanding balance that may occur. I also understand that if my bill becomes 90 days past due the full-owed amount will be charged to this credit card automatically. I agree that I will pay for this purchase and indemnify and hold Collaborative Counseling & Psychiatry, LLC harmless against any liability pursuant to this authorization.
I understand that my signature on this form will serve as authorized signature on the credit card charge slip.

Card Holder's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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