



Authorization for Credit Card Use

PRINT AND COMPLETE THIS AUTHORIZATION AND RETURN.
All information will remain confidential

Name on Card: _____

Billing Address: _____

Credit Card Type: ___ Visa ___ Mastercard ___ Discover ___ AmEx

Credit Card Number: _____

Expiration Date: _____

Card Identification Number: _____ (last 3 digits located on the back of the credit card)

Amount to Charge: \$ _____ (USD)

Please circle frequency: Per Session Per Month Per other: _____

I authorize, Center for Family Psychiatry, PLC, to charge the amount listed above to the credit card provided herein. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder – Please Sign and Date

Signature: _____

Date: _____

Print Name: _____

Return the completed and signed form to the following:

Center for Family Psychiatry
1235 Industrial Dr.
Suite 4
Saline, MI 48176
centerforfamilypsych@gmail.com