Credit Card Authorization Form

Card Holder Information:

Name:____

Address:____

City_________________________ State____________ Zip Code_______________________

Email Address:_________________________________ Phone Number:__________________

Payment Authorization:

Card Type: ______Visa ______Mastercard _______Discover ______American Express

Card Number _______________________________ Expiration Date ______/________

CVV (Card Identification Number)Code _______________________

I, _________________, authorize Dr. Carrie Poline, to process the charges outlined in the treatment contract for Psychiatric Services, no show/late cancellation fees, and balances for any services provided.

Print Name as it appears on Credit Card: ____

Signature: ____

Date:____