CREDIT CARD AUTHORIZATION _____

(Patient Name)

I authorize _____ to keep my signature on file and to charge my credit card
(Name of Counselor)
as indicated below. I understand this will remain in effect until the credit card expires or until I cancel this authorization.

Check One:
_____MasterCard
_____Visa
_____Discover
_____AmerExpress

_____
Cardholder Name

_____ _____
Cardholder Billing Address City State Zip Code

_____ _____ _____
Account Number **Expiration Date** **Security Code**

_____ _____
Cardholder Signature Date

Date	Amount	Cardholder Initial	Date	Amount	Cardholder Initial
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Changes to above: _____

_____

Date:_____ Cardholder Initial_____