Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization is in effect until it is cancelled.

Date: _____

Patient Name: _____

Provider: _____

Patient DOB: _____

Patient Address: _____ _____ _____

Patient Phone Number: _____

Patient Email Address: _____

Credit Card Information

Card Type: ___Mastercard ____Visa ___Discover ____AMEX ____Other: _____

Cardholder Name (as shown on card): _____

Card Number: _____ Three Digit Code on Back of Card: _____

Expiration Date (mm/yy): _____

Cardholder Zip Code (from credit card billing address): _____

I, _____, authorize Midlands Psychiatric Services to charge my credit card above for agreed upon services. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Patient Signature Date