**CREDIT CARD AUTHORIZATION**

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| **Date :**  | **Patient Name:** | **Office Account No.:**  |
| **Credit Card Authorization** |
| Credit Card Holder’s Name: (Please print as it appears on the card) |
| **Mailing Address Where Credit Card Statement is Sent:** |
| Street Address:  | City: |  State: Zip Code: |
| Home Phone:  | Email:  |
| \_\_\_\_\_Initial ***I hereby authorize charges to my credit card for services rendered by Next Step Psychology that are not paid directly in cash or check.***\_\_\_\_\_Initial ***I understand that late or non-cancelled (no show) visits will be charged to my credit card.*** \_\_\_\_\_Initial ***I understand that it is my responsibility to notify office personnel if I change my credit card companies and/or numbers.***\_\_\_\_\_Initial ***I will update the expiration date of my credit card when necessary.***  |
| **Credit Card Information** |
| Credit Card Company: □ Visa □ Master Card □ Other \_\_\_\_\_\_\_\_\_\_\_\_ |
| Credit Card Number:  \_\_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_ |
| Credit Card Three Digit Security (CCV#):  \_\_\_\_\_\_ |
| Expiration Date:  \_\_\_\_\_\_ / \_\_\_\_\_\_\_ |
| Signature: Date:  |