**CREDIT CARD AUTHORIZATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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: | | | | |