CREDIT CARD AUTHORIZATION

DATE:	PATIENT NAME:	OFFICE ACCOUNT NO.:
CREDIT CARD AUTHORIZATION		
NAME ON CREDIT 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 Meredith Furr, LCMHC-A 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: