Credit Card Payment Authorization Form

Patient Name:____

Billing Address:____
(No PO Box)
City: ____________________ State: ____________ Zip code: ______________________

Phone Number:_________________________ Cell Number:_______________________

Credit Card Type: ___MasterCard ___ Visa ___ Discover ___American Express

Credit Card Number: ____________________________ Expiration Date: _____________

CVV: ______________ Billing Zip code: _____________

Account Balance: $ ________ Amount Charge: $_________ Remaining Balance: $_______

I authorize In-Touch Psychiatry, Inc. to bill this card for the amount listed above.

Monthly Charged______ Paid by Phone_______ In Person _______ By Mail_______

Patient Signature:___________________________________ Date: _________________

Office Representative: _________________________________ Date: _________________