CREDIT CARD AUTHORIZATION

Date: ___________ Patient Name: ______________________ D/O/B: __________

Cardholder Name: ____

Billing Address: ____
Street City/State Zip

Phone: ______________

Visa: ______ MasterCard: _______ Discover: _________

16-digit credit card #: ____

Expiration Date: _____/_____/______

Security Code: { Visa/MasterCard (3 digit number on back of the card):______________

TOTAL Amount: $ __________

____
Print Cardholder Name Signature Date

I authorize Behavioral Collaborative Care Solutions, LLC to charge my credit card as outlined above today or in the future.