

Authorization to Charge Credit Card

Card Front

Card Back

Copies may be provided on the back of this form or on a separate sheet, if desired.

Number: _____

Exp. Date: _____ **Sec. Code:** _____

Name on Card: _____

Address where credit card bill sent: _____

Card Holder Phone #: _____

I, _____, legal card holder of account

Card holder name

**listed above, have requested of and give authorization to
Stonebriar Psychiatric Services, P.A. to charge to this card**

all fees* billed from this date forward to the account of

patient name

the sum of: _____ to be applied

to the account of _____

patient name

Signature

Date

* Including, but not limited to sessions, phone consults, missed appointments, Rx refills