Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled or client is discharged.

Credit Card Information
Card Type: ☐MasterCard ☐VISA ☐Discover ☐AMEX ☐Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____CVV:_____
Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize ***Dennis Gates Mental Health LLC*** to charge my credit card above for agreed upon fees. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Patient or Legal Guardian Signature Date