ASSOCIATED PSYCHOLOGISTS

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CREDIT CARD AUTHORIZATION FORM

I hereby authorize Dr. _____ to use the credit card listed below

to bill for services rendered to his/her client _____

in the amount of $ _____.

CLIENT NAME: _____

NAME ON CREDIT CARD: _____

CREDIT CARD NUMBER: _____

TYPE OF CARD & EXP. DATE: _____

AUTHORIZED SIGNATURE: _____

BILLING ADDRESS: _____

CITY, STATE, & ZIP: _____

PHONE NUMBER: _____

WORK NUMBER: _____