ASSOCIATED PSYCHOLOGISTS

T: (949)716-5150

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: ____

CVV CODE: ____

AUTHORIZED SIGNATURE: ____

BILLING ADDRESS: ____

CITY, STATE, & ZIP: PHONE ____

NUMBER: ____

WORK NUMBER: ____