Credit Card Authorization Form

In providing us with your credit card information, you are giving *Child & Family Counseling Group* permission to charge your credit card for all patient(s) you have listed below.

Please complete all information below: (to be completed by cardholder/guardian)

Patient Full Name: ______________________________ Date of Birth: _____/______/______
(Please Print)

Patient Full Name: ______________________________ Date of Birth: _____/______/______

Patient Full Name: ______________________________ Date of Birth: _____/______/______ Ee

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX

Cardholder Name (as shown on card): ______________________________

Card Billing Address: ______________________________

Email Address: ______________________________

Phone Number: ______________________________

Card Number: ______________________________

Expiration Date (mm/yy): ______________ CVV: __________

______________________________ ______________________________
Card Holder Signature Date

(To Be Completed by Provider Only)	
Provider Initials:	
Date of Service:	Amount Billed:
Diagnosis Code:	Procedure Code(s):