Dill- Standiford Psychological Associates
Recurring Credit Card Charge
Authorization Form

I hereby authorize Dill-Standiford Psychological Associates to make recurring charges to my Credit Card listed below, and, if necessary, initiate adjustments for any transactions credited/debited in error. If this authorization is for a one-time only charge please check here. □

This authority will remain in effect until Dill-Standiford Psychological Associates is notified by me in writing to cancel it.

_____

Name (AS APPEARS ON CARD)

_____

Billing Address

Please circle one: Visa / MasterCard / Discover / American Express

CARD NUMBER : _____

Expiration Date: _____ CVV Code :_____

Charge Amount: _____ Billing Zip Code: _____

_____ _____

Signature Effective Date

Dill-Standiford Psychological Associates
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Langhorne, PA 19067

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