Center for Dialectical and Cognitive Behavioral Therapies, LLC
291 Whitney Avenue, Suite 301
New Haven, CT 06511

AUTOMATIC BILLING AUTHORIZATION FORM

FROM CREDIT CARD

I authorize you to charge my bill (or that of the named patient below) directly to the credit card listed below. This authority is valid until I provide you written notification of cancellation. I understand the amount may vary due to differing fees for services, co-pays, and cancellations with less than 24 hours notice.

__________Visa ____________Master Card _________Discover

__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ ____/____ ____________

Credit Card Number **Expiration** **Security Code**

____________________________________ ______________________________

Name on Card For Patient Name (If different)

____

Street Address for Credit Card

____________________________________ ________________________

City, State **Zip Code**

__________________________________ ________________________

Signature **Date**