Credit Card Authorization Form

I, the undersigned individual, authorize **Manhattan Wellness Psychiatry, PLLC** to charge my credit card for outstanding payments on all services rendered. I am also authorizing charges for any appointments missed or rescheduled within less than a 48-hour notice as per this practice policy.

I authorize **Manhattan Wellness Psychiatry. PLLC** to charge my credit card for the full amount due for the services provided.

I understand this form will be securely stored in my clinical file and may be updated, or voided upon my request at any time.

Card Type (please circle one): Visa MasterCard Discover American Express

Card #: _____

Expiration Date: _____

Name (as printed on card):_____

Verification/Security Code (3-digit code or 4 digits for AMX): _____

Billing Zip Code: _____

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(Client Signature/Client's parent or legal guardian) (Date)