Pre-Authorized Healthcare Form

I authorize DIVINE PSYCHOLOGY to keep my signature on file and to charge my Visa, MasterCard, or Discover as indicated below:

Single/One-Time Charge or **Recurring Charges** (circle one)

Visa MasterCard Discover (circle one)

Card Expiration Date: _____

I understand this form is valid unless I cancel this authorization by written notice. If I choose to cancel this form, I assume full responsibility for paying my charges in full at the time of service or making alternative arrangements for payment.

_____

Patient Name

_____

Cardholder Name

_____

Cardholder Billing Address

_____

City State Zip

_____

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