Progressive Psychiatry Authorization Form for Credit Card Use

PRINT AND COMPLETE THIS AUTHORIZATION AND RETURN.

All information will remain confidential.

Name on Card: _____
Email Address: _____

Patient name if different:_____

Billing Address:
_____
_____
_____

Credit Card Type: _____ Visa _____ Mastercard ____ Discover _____
AmEx Credit Card Number: _____-_____-_____-_____
Expiration Date: _____/_____ Card Identification Number: _____ (last 3 digits located on the back of the credit card)

Amount to Charge: $ _____ (USD) I authorize Sara Markey, MD/Progressive Psychiatry to charge the amount listed above to the credit card provided herein. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder – Please Sign and Date Signature:
_____

Date: _____