DIVERSIFIED PSYCHOTHERAPY, INC

Credit Card Authorization Form

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CARDHOLDER INFORMATION

Name:_____

Billing Street Address:_____

City:_____ State:_____ Postal Code:_____

Country:_____ Email _____

Address:_____

Direct Telephone: (_____)_____-_____

INFORMATION

Purpose: PSYCHOTHERAPY INITIAL AND FOLLOW-UP SESSIONS

□ I authorize a recurring charge against my credit card for either co-pays/session payments beginning

_____.

CREDIT CARD INFORMATION

Credit Card Type: □ MasterCard □ Visa □ American Express □ Discover Card

Number:_____

Expiration Month:_____ Expiration Year:_____

Cardholder Signature X_____ Date___/___/___

Security Code:_____

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