CREDIT CARD AUTHORIZATION FORM

I allow Psychology Associates of Grand Rapids, PC to electronically store my credit card information on file

□ Please use my stored credit card information to pay my balance in full on the 5th _____, 20th _____, both days _____.
I do___, do not, ____need to receive a monthly receipt.

□ Please only use my stored credit card information to process a monthly payment on my outstanding balance.
Please bill my card $_____/month until my balance is paid in full.
I would like my payment to be processed on the (please specify):

5th ____ and/or 20th _____ day of the month. Please note that due to holidays or weekends this day could vary by a couple of days later than you specify.
I do___, do not, ____need to receive a monthly statement.

Patient Name: _____ DOB: _____
Cardholder Printed Name: _____
Cardholder Signature: _____

Date: _____

.....

CC#: _____ Exp. Date:_____

CVV: _____

The credit card numbers listed above will be stored electronically in our billing system. Once they are entered the bottom portion of this form will be shredded.