CREDIT CARD AUTHORIZATION

Client Name: _____

Name on Card:_____

Cardholder's Phone Number: _____

Cardholder's Address:_____

_____

(zip code)

Specify Type of Credit Card:

Credit Card
Debit Card
Flex Spending/HSA Card

Card Number: _____ CSC #_____

(3 digit # on back)

Expiration Date: ____/____
Clinician: _____

Date of Service: ____/____/_____

Charge Amount: $ _____

I, _____, authorize Breakthroughs Psychological Services, LLC (BPS) to bill my credit card for the amount indicated above and/or for any ongoing balances on my account.

_____

Signature of Card Holder (Responsible Party) Date