

**Authorization To Use Credit Card**

I authorize \_\_\_\_\_ of Psychological Resource  
[Therapist]  
Associates to keep my signature on file and to charge my Visa or MasterCard  
account for:

\_\_\_ Monthly balance of charges due by patient and/or guarantor.

\_\_\_ Balance of charges not paid by insurance within 90 days and not to  
exceed \$ \_\_\_\_\_ per visit.

\_\_\_ Recurring charges (on-going sessions) of \$ \_\_\_\_\_ monthly from the  
start date \_\_\_\_\_ to the end date \_\_\_\_\_.

I understand that this form is valid for one year from the date of signing unless  
I cancel the authorization through written notice to the above mental health  
provider.

Patient Name: \_\_\_\_\_

Credit Cardholder Name & Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Credit Card Account Number: \_\_\_\_\_

Card Expiration Date: \_\_\_\_\_

3-digit Security Code: \_\_\_\_\_

Receipts for each transaction will be mailed to the credit cardholder's address  
as indicated above.

*Cardholder's* Signature: \_\_\_\_\_

Date: \_\_\_\_\_