

## Credit Card Authorization

I, \_\_\_\_\_, authorize  
(please print name as it appears on your credit card)

Comprehensive Psychiatric Associates to submit charges for professional services  
provided for \_\_\_\_\_  
(name of client)

to my credit card. This authorization will be in effect until I notify Comprehensive  
Psychiatric Associates in writing to discontinue this authorization. This  
authorization applies to all legitimate charges applicable to the above named  
individual, including all currently outstanding charges and all future charges.

\_\_\_\_\_  
Card Type  
(Visa, Mastercard, Amer Exp, Discover)

\_\_\_\_\_  
Card Number

\_\_\_\_\_  
Expiration Date

\_\_\_\_\_  
Name of Card Holder, Printed

\_\_\_\_\_  
Signature of Card Holder

\_\_\_\_\_  
Date of Signature

Your card will be charged only if you do not pay at the time of your visit, or if there  
are outstanding charges for deductibles, co-payments, missed appointments, late  
cancellations, or service charges. You will be notified in writing any time we have  
made a charge to your credit card.