PATHWAY
PSYCHIATRY & COUNSELING CENTER

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us at 214-997-4459.
This authorization will remain in effect until cancelled.

Credit Card Information

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____

Cardholder Name (as shown on card): _____

Card Number: _____

Expiration Date (mm/yy): _____ Security Code:_____

Cardholder ZIP Code (from credit card billing address): _____

Is there anyone other than yourself that we may speak to about payment of your account (i.e. if the card above belongs to someone other than yourself).

Name: _____

Phone number: _____

I, _____, authorize Pathway Psychiatry and Counseling Center, PLLC, to charge my credit card above for services, as outlined in the clinic policies and procedure document which I have received. I understand that my information will be securely saved on file for future transactions on my account, per the above clinic policies.

I understand that my initial 60 minute session will be billed at a rate of $250 for the session and agree to pay this fee. This charge will be submitted on the day of my appointment. I have read the "Practice Policies and Procedures" document and understand the clinic cancellation policies.

_____

Cardholder Name (printed)

_____ _____

Cardholder Signature Date