

Credit Card Authorization Form

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

Credit Card Information	
Card Type:	<input type="checkbox"/> MasterCard <input type="checkbox"/> VISA <input type="checkbox"/> Discover <input type="checkbox"/> AMEX <input type="checkbox"/> Other _____
Cardholder Name (as shown on card):	_____
Card Number:	_____
Expiration Date (mm/yy):	_____ CVV (3 Digit code on back): _____
Cardholder ZIP Code (from credit card billing address):	_____
Email address for Receipts:	_____

Please also indicate how much of your outstanding balance (if you have one) you would like to be charged to your card at this time.

Also, how would you prefer your future copays to be charged?

_____ After each appointment OR

_____ At the end of the month

I, _____, authorize M & M Behavioral Health Solutions to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

Customer Signature

Date