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Authorization for Credit Card Use

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6613 B Bay Laurel Place, PO Box 2589, Avila Beach, CA 93424

Office: 805-459-8232
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COMPLETE THIS AUTHORIZATION and click “Submit” on the bottom of the form.

All information will remain confidential and protected.

Patient Name:

Name on Card:

Billing Address:

Credit Card Type:
- ○ Visa
- ○ Mastercard
- ○ Discover
- ○ AmEx

Credit Card Number:

Expiration Date: MM / YY

Card Identification Number:
(last 3 digits located on the back of the credit card)

I authorize WellMind LLC to charge the amounts listed in my Treatment Agreement for services provided to me during my treatment to the credit card provided herein. I agree to pay for these purchases in accordance with the issuing bank cardholder agreement.

X _____

Signature Certificate

Document name: Authorization for Credit Card Use

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LEGALLY SIGNED USING WPesignature
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This audit trail report provides a detailed record of the online activity and events recorded for this contract.