Authorization for Credit Card Use

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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:

(3 or 4 four digit code located on the front or 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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