CREDIT CARD AUTHORIZATION FORM

I hereby authorize Riverview Center for Psychiatric Medicine, to keep my signature on file and charge my credit card account.

☐ For recurring charges relating to on-going treatment

I understand that this form is valid for one year.

PATIENT NAME: ____

CARDHOLDER NAME: ____________________________________

CARDHOLDER ADDRESS: __________________________________

____

CREDIT CARD: ☐ **VISA** ☐ **MASTERCARD**

CREDIT CARD ACCOUNT NUMBER: _________________________

EXPIRATION DATE: ________________

____ ____________

SIGNATURE OF CARDHOLDER DATE