Authorization for Credit Card Use PLEASE COMPLETE THIS AUTHORIZATION AND RETURN. All information will remain confidential. Name on Card: _________

Billing Address: ____

City State Zip Code____

Credit Card Type: ____ Visa ____ Mastercard ____ Discover ____ AmEx Credit Card Number: ____

Expiration Date: ____

Card Identification Number: __________ (3 digits located on the back of the card) I authorize Shafa Psychiatry Center to charge the amount to cover services or products requested or provided. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement. Cardholder - Please Sign and Date Signature: ____

Date: ____

Print Name: ____

Email the completed form