Credit Card Authorization

Third Party Payer

I,_____, hereby authorize Gateway Psychiatric Services to charge my credit card to pay for sessions and any other charges incurred by patient _____.

I affirm that I am at least 18 years old and that I am legally authorized to use the credit card account number specified below.

If the information listed below changes, I will let Gateway Psychiatric Services know immediately.

☐ Visa ☐ MasterCard

Account Number:_____

Expiration: _____/_____

Name (as it appears on the card):_____

Credit Card Billing Address:

Street:_____

City:_____

State:_____

Zip Code:_____

Telephone:(___)_____-_____

_____ _____

Signature of Cardholder Date