gateway
psychiatric
services

Credit Card Authorization

I,_____, hereby authorize Gateway Psychiatric Services to charge my credit card to pay for my sessions and any other charges I incur at Gateway Psychiatric Services. 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. I understand that I will be charged for the initial consultation session prior to that visit. All other charges will take place on the date of the session or within a week of the session.

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

○ Visa ○ MasterCard ○ Discover ○ American Express

Name (as it appears on the card):_____

Account Number:_____

Expiration: _____/_____ CVV #: _____

Credit Card **Billing Address**:

Street:_____

City:_____

State:_____

Zip Code:_____

Telephone:_____

_____ _____

Signature of Patient and Cardholder Date