Credit Card Authorization Form

PLEASE COMPLETE THIS AUTHORIZATION AND RETURN
pd@pauldavidphd.com

Client Name (s) _____ Date _____

Full Name as it appears on Card _____

Type of Credit Card _____ Card Zip Code _____

Credit Card # _____ Exp. Date _____

Card Security Code _____

I authorize Paul David, Ph.D., to charge on the above designated credit card all balances due for the clinical services he has provided.

Cardholder - Sign and Date Below:

Signature _____

Date _____