Psychiatric Medicine Center, LLC
5 Shaws Cove, Suite 207, New London CT, 06320

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information

Card Type: ☐ **MasterCard** ☐ **VISA** ☐ **Discover** ☐ **AMEX**

Other: _____

Cardholder Name (as shown on card): _____

Card Number: _____ - _____ - _____ - _____

Expiration Date (MM/YY): _____ / _____ CVV: _____

Cardholder ZIP Code (from credit card billing address): _____

Check Below:

- ☐ I authorize Psychiatric Medicine Center to securely store my credit card.
- ☐ I understand that I am responsible for updating this credit card information as needed.
- ☐ I authorize Psychiatric Medicine Center to automatically charge my card for any copays/balances I may owe.
- ☐ I do not authorize Psychiatric Medicine Center to automatically charge my card for any copays/balances I may owe.

_____ _____

Patient Signature Date