



**Credit Card Pre-Authorization Form**

I authorize Psychology Associates of Chester County, Inc to keep my signature on file and to charge the credit/debit card selected below for the following:

- This visit only (\$\_\_\_\_\_)
- Balance due on account not to exceed \$\_\_\_\_\_
- All visits this calendar year
- All visits from \_\_\_\_\_ to \_\_\_\_\_  
(date) (date)
- Recurring charges of \$\_\_\_\_\_ to be charged every \_\_\_\_\_  
(frequency)  
From \_\_\_\_\_ to \_\_\_\_\_  
(date) (date)

**Charges for the following family members:**

|                            |                            |
|----------------------------|----------------------------|
| _____                      | _____                      |
| (authorized family member) | (authorized family member) |
| _____                      | _____                      |
| (authorized family member) | (authorized family member) |

**Check One:**

- Visa®
- MasterCard®
- Discover Card®

Patient Name: \_\_\_\_\_

Cardholder Name: \_\_\_\_\_

Cardholder Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Credit Card Number: \_\_\_\_\_ CVV: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Cardholder Signature: \_\_\_\_\_ Date: \_\_\_\_\_