Cruz Clinic/Integrative Psychology Credit Card Authorization Form

Patient Name			Patient Date of Birth	
□ Visa □ MasterC	Card □ Discover	□ American Express		
Cardholder Name			_	
			_	
Cardholder Address				
City	State	Zip	_	
Credit Card Number	ſ			
Expiration Date		Security Code	_	
I AUTHORIZE CRUZ	CLINIC TO CHARG	E MY CREDIT CARD FOR	PAYMENT/S TO BE PROCESSED:	
□ AT EACH T	TIME OF SERVICE	□ TOTAL BALÆ	ANCE ON LAST DAY OF MONTH	
□ PER PAYM	ENT AGREEMENT \$			
PLEASE READ AND	INTIAL BELOW:			
AUTHORATION AN	D CONSENT TO PRO		KNOWLEDGES THAT I VOLUNTARILY GIVE MY D INFORMATION FOR MY CREDIT CARD TO BE IIS FORM.	
I UNDERS THROUGH WRITTE			(DATE/YEAR) UNLESS I CANCEL	
CLINIC CHARGE YOU IN CONJUNCTION V	OUR CREDIT CARD I VITH HIPAA REGUL	FOR ANYTHING OTHER T	FORM, UNDER NO CIRCUMSTANCES WILL CRUZ HEN WHAT IS LISTED ON THIS FORM. RD INFORMATION WILL BE CONFIDENTIALLY KEPT S INFORMATION.	
			/	
Patient signature or	authorized person		Date	
Witness signature			Date	
RECIEPTS CAN E	BE MAIL TO: □	ADDRESS IN ACCO	UNT THE CARDHOLDER'S ADDRESS	