Psychology Associates
OF CHESTER COUNTY, PC

Credit Card Pre-Authorization Form

I authorize Psychology Associates of Chester County, PC 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)

❑ All 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® ❑ American Express®
❑ MasterCard® ❑ Discover Card®

Patient Name: _____

Cardholder Name: _____

Cardholder Address: _____

City: _____ State: _____ Zip: _____

Credit Card Number: _____ CVV: _____ Exp. Date: _____

Cardholder Signature: _____**Date**: _____