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.

Patient Name: _____

**Note: family members using the same card - list all names that apply*

Doctor/Therapist Name: _____

Credit Card Information

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX

☐ Other _____

Cardholder Name (as shown on card): _____

Card Number: _____

CVV code: _____

Expiration Date (mm/yy): _____

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

Email: _____

I, _____, authorize **Dr. Mohab Hanna and/or MedPsych Associates of NJ** to charge my credit card above for agreed upon purchases.

I understand that my information will be saved to file for future transactions on my account.

Signature _____ Date _____