

**Authorization for Credit Card Payment of Fees to the  
Anxiety and Agoraphobia Treatment Center, Ltd.**

I, \_\_\_\_\_, authorize the payment of fees for \_\_\_\_\_  
*(your name)* *(patient's name)*  
to the Anxiety and Agoraphobia Treatment Center, Ltd., (A.A.T.C., LTD.), for services rendered.

**I authorize the following:**  
*(Please check all that apply)*

\_\_\_\_\_ payment of my balance in full

\_\_\_\_\_ payment of my monthly balance in full

\_\_\_\_\_ payment of my balance whenever I forget a check or cash payment at time of therapy session

**Credit Card Information**

My credit card is *(please check)* \_\_\_\_\_ VISA \_\_\_\_\_ MasterCard

My account number is \_\_\_\_\_ expiration date *(month/year)* \_\_\_\_\_

The security numbers listed on the back of the card under the signature area are \_\_\_\_\_

My credit card is listed under the name and address of *(please print)*

\_\_\_\_\_  
\_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_