

Anxiety and Agoraphobia Treatment Center, Ltd.

Authorization for Credit Card Payment of Fees

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 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: _____