Fulton Psychological Group

Patient:_____ _____ Dr. Name:_____

Credit Card Authorization

I, _____, hereby authorize Fulton Psychological Group to use the following credit/debit card to pay for any service or charge incurred. If there is an outstanding balance with the practice, I give permission to use the card to pay the balance in full. This authorization is good until the balance is paid in full, the cardholder has rescinded the authorization or services are terminated with the practitioner.

Credit Card Number: _____

Expiration: _____ CVV: _____

Address associated with card (including zip code): _____

Printed Name on card: _____

Signature of card holder: _____ Date: _____

Visa, Mastercard and Discover only.

Please note: there is a 3% processing fee for using credit cards.