



www.metamorphosispsyche.com

CREDIT CARD AUTHORIZATION FORM:

Client's Name: _____ Parent/Guardian's Name: _____

Client/Guardian email address: _____

Client's Address: _____

City: _____ State: _____ Zip code: _____

Client Phone number: _____ Parent/Guardian phone#: _____

Credit/Debit Card Type: _____

Credit/Debit Card Number#: _____

Exp. Date: _____ CVV (number on back of card) _____

Name as it appears on card: _____

Card Billing Address: _____

City: _____ State: _____ Zip code: _____

By signing this form, I hereby authorize Metamorphosis Psyche LLC to charge my card for services rendered. I agree for Metamorphosis Psyche LLC to charge my card for the cost of the initial evaluation and ALL follow-up evaluations (copay, co-insurance, self-pay, etc.). I will notify Metamorphosis Psyche LLC in writing when this agreement is terminated.

Authorized Card User Signature: _____

Printed Name: _____

Date: _____