Mental Health Solutions

Recurring Credit Card Payment Authorization Form

Sign and complete this form to authorize Mental Health Solutions to debit a charge to the credit card listed below.

By signing this form you give us permission to debit your account for the balance owed currently and to charge your card automatically for the payment plan to which you have agreed.

Please complete the information below:

I _____ authorize Mental Health Solutions to charge my credit card
(Full name)

account indicated below in the amount of _____ to be charged on the _____of each month.

Billing Address _____ Phone#_____

City, State, Zip _____ Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV2 (3 digit number on back of Visa/MC, 4 digits on front of AMEX) _____

SIGNATURE _____ DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.