

Link Psychiatry

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**CREDIT CARD AUTHORIZATION FORM**

PLEASE PRINT CLEARLY

Name on card \_\_\_\_\_  
LAST FIRST MIDDLE

Address \_\_\_\_\_  
STREET CITY STATE ZIP

I hereby authorize Link Psychiatry to charge my credit card for my portion of the fees for the care of \_\_\_\_\_ (name).

Card Type:        Mastercard            VISA            Discover            Amer. Express

Credit Card Number \_\_\_\_\_            Expiration Date \_\_\_\_\_  
MM/DD/YEAR

Verification Code \_\_\_\_\_  
(last three digits on signature panel for most cards; four digits on front of AMEX card)

Billing Address  
Same as above  
Different from above

Address \_\_\_\_\_  
STREET CITY STATE ZIP

Phone Number Associated with Account \_\_\_\_\_

Signature \_\_\_\_\_            Date \_\_\_\_\_