Feathergill and Associates, LLC
3625 Park Place West, Suite 150
Mishawaka, IN 46545

CREDIT CARD AUTHORIZATION FORM

Date: _____

Credit Card Type:

_____Visa _____ Mastercard _____American Express _____Discover

Name on Card: _____

Credit Card Number: _____

Expiration Date: _____ / _____ 3 Digit CVV: _____
(mm) (yy)

Zip Code: _____

The name on the above credit card must match the name of the person authorizing charges.

I, authorize Feathergill and Associates, LLC to charge the above credit card for all charges posted to my account in accordance with the Billing Polices and Procedures, which I have reviewed with my therapist.

_____ _____
Signature Date