Credit Card Authorization Form

Connecticut Psychiatric & Wellness Center requires a credit/debit card to be kept on file for payment. Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Please print clearly

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I,_____, authorize CPWC to charge my credit card above for fees as indicated by my insurance coverage and/or for private pay services. I understand that my information will be saved to file for future transactions on my account. This information will not be shared, and I understand that I can request a receipt at any time by contacting the office.

_____ _____
Customer Signature Date