PETE A. MORONES, Ph.D.
Licensed Psychologist
3310 SE Division St.
Portland, OR 97202
503-236-4665

CREDIT CARD AUTHORIZATION FORM

Card Holder Name (as it appears on credit card):____

Client Name: ____

Type of Card:

______VISA ______ MasterCard _____ AMEX _____ Discover _____ Medical Savings Card

______Other Card (please specify):____

Card Number: __________ -__ ________ - __________ - __________

Expiration Date: ___________________________

Verification/CVV/Security Code: ____________

Billing Address for Card:

Street: ____

City:____

State:_________________ Zip Code:_____________________________________

I , _____________________________________, authorize ***Dr. Pete Morones*** **to charge my credit/debit card per the terms of the** ***Consent To Treatment & Office Policies Form*****, including fees for no shows or late cancellations and outstanding balances.**

Card Holder Signature: _______________________________________, Date: __________________