INTEGRAL HEALTH ASSOCIATES

437 Orange Street, New Haven, CT 06511 Tel (203) 909-6370, Fax (203) 909-6374, Alt Fax (203) 777-6776

CREDIT CARD AND DEBIT CARD AUTHORIZATION FORM

Patient Name: _____ Date of Birth: _____

Cardholder Name: _____
(as shown on card)

Billing Address: (Street Address) _____

(City, State, Zip) _____

Card Type: ____ Visa ____ MasterCard ____ Discover ____ AMEX

Card Number: _____

Expiration Date: _____/_____ CVV Code: _____
(mm/yy) (3 or 4 digits)

I, _____, authorize Integral Health LLC, doing
(Credit or Debit card account holder or authorized user)
business as Integral Health Associates, a mental health practice in the state of Connecticut, to charge the credit or debit card referenced above for all balances due or overdue as of the date this authorization is signed and all future balances at the time they are due for services and fees associated with such services provided by Integral Health Associates to _____.
(Patient name)

This agreement replaces all previous credit and debit card authorization agreements between myself and Integral Health Associates.

- I understand that I may cancel this authorization at any time.
- I understand that the above information will be kept on file and used for future charges to the account of the patient referenced above.

This authorization will remain in effect as long as the patient above is in the care of Integral Health Associates or until explicitly canceled.

_____ _____
(Signature of credit or debit card account holder or authorized user) *(Date signed)*

I hereby cancel my authorization to charge my credit card on file.

_____ _____
(Signature of credit or debit card account holder or authorized user) *(Date signed)*