Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Patient Name: _____

family members using the same card - list all names that apply

Note: If this is an FSA/HSA card, please provide an additional card to be used as a backup, should this one decline. We will always try to use the card you specify first.

Primary Payment Method:

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____

Cardholder Name (as shown on card): _____

Card Number: _____Exp (mm/yy): _____

CVV code: _____ ZIP Code (from credit card billing address): _____

Alternate Payment Method:

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____

Cardholder Name (as shown on card): _____

Card Number: _____Exp (mm/yy): _____

CVV code: _____ ZIP Code (from credit card billing address): _____

With my signature below or my E-Signature through the Patient Portal,

I, _____, authorize **MedPsych Associates of New Jersey** to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

Email: _____Phone Number: _____

Signature:_____ Date:_____