



Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by submitting a written request.
This authorization will remain in effect until cancelled.

Credit Card Information	
Card Type:	<input type="checkbox"/> MasterCard <input type="checkbox"/> VISA <input type="checkbox"/> Discover <input type="checkbox"/> AMEX <input type="checkbox"/> Other _____
Cardholder Name (as shown on card):	_____
Card Number:	_____
Expiration Date (mm/yy):	_____
Cardholder ZIP Code (from credit card billing address):	_____

I, _____, authorize Orange Psychiatric Medical Group, Inc 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.

Customer Signature

Date