ABHS Credit Card on File Authorization Form

Please complete ALL fields. You may cancel this authorization at any time by contacting us (call 614-436-5030 ext. 7, or inform your individual therapist who can let our billing agent know). If you cancel this authorization without providing a new, authorized card, any further appointments you have scheduled will be canceled (until you provide new authorization). This authorization will remain in effect until cancelled.

Card type (circle one): MC / VISA / Discover / AMEX

Other type of card: _____

Cardholder Name (as shown on card): _____

Card Number: _____

3-Digit Security Code (back of card): _____

Expiration Date (MM/YY): _____

Cardholder ZIP code (from credit card billing address): _____

Customer Email address (required): _____

I, (print your name here:) _____ ,

authorize Beth T. McCreary, PhD, LLC, OR Joseph P. DeCola, PhD, LLC (whichever is the relevant ABHS entity) to charge my credit card above for agreed upon services. I understand that my information will be saved to file for future transactions on my account.

_____ _____

(Sign above) (Date)