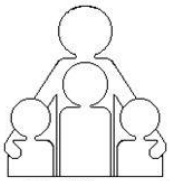

Family Guidance Center
of Milford, Inc.

CREDIT CARD AUTHORIZATION FOR

After each appointment, your credit/debit/HRA/FSA card will be charged your copay, coinsurance, or deductible amount, unless you provide another form of payment.

If your coinsurance or deductible amount has not yet been determined, an estimate based upon your individual insurance benefit will be charged. Any overpayments will be credited to future appointments, or refunded.

If you have an outstanding balance at the end of treatment your credit card will be charged.

I,_____, authorize Family Guidance Center of Milford, Inc., to charge my credit card for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

Please fill out credit card information Below

_____ _____
Cardholder Signature Date

_____ _____
Client Name Client Date of Birth

Client Name: _____ Date of Birth: _____

Cardholder Name (as shown on card): _____

Cardholder Billing Zip Code: _____

Card Type: ☐ American Express ☐ MasterCard ☐ Visa ☐ Other: _____

Card Number: _____

Expiration Date (MM/YY): _____ Security Code: _____

THIS SLIP WILL BE STORED IN OUR SECURE FILES

Family Guidance Center of Milford, Inc.
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