

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.		
, authorize Family Guidance Center of Milford, Inc., to charge		
my credit card for agreed upon purchases. I understand t	hat my informati	ion 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

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Fax: 603-672-6501