Dallas Family Psychiatry LLC
Credit Card Payment Authorization Form

Patient Name:_____

Billing Address:_____
(No PO Box)
City: _____ **State:** _____ **Zip code:** _____

Phone Number:_____ **Cell Number:**_____

Credit Card Type: ___**MasterCard** ___ **Visa** ___ **Discover** ___**American Express**

Credit Card Number: _____ **Expiration Date:** _____

CVV: _____ **Billing Zip code:** _____

Account Balance: $ _____ **Amount Charge: $**_____ **Remaining Balance: $**_____

I authorize Dallas Family Psychiatry LLC to bill this card for the amount listed above.

Monthly Charged_____ **Paid by Phone**_____ **In Person** _____ **By Mail**_____

Patient Signature:_____ **Date:** _____

Office Representative: _____ **Date:** _____