Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until canceled.

Credit Card Information

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX

☐ Other _____

Cardholder Name (as shown on card): _____

Card Number: _____

Expiration Date (mm/yy): _____

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

I, _____, authorize Milestones Mental Health & Wellness to charge my credit card above for agreed upon fees. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Responsible Party Signature Date