Didi Hirsch Mental Health Services Credit Card Authorization Form

Name:

Street Address:

City/State/Zip:

Phone Number: Email:

Please charge my: ☐ VISA ☐ MC ☐ AMEX

Card #:

Expiration date: CVV#:

Amount: Session Date:

Client's Signature: Date:

☐ I authorize DHMHS to keep my financial information on file until current services are completed. This document will be destroyed after the last date of service.

☐ I do not authorize DHMHS to keep my financial information on file, and I will submit a new authorization form prior to each service.