



## 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. Please note, it is required to have a card on file with us.

Credit Card Information	
Card Type:	<input type="checkbox"/> MasterCard <input type="checkbox"/> VISA <input type="checkbox"/> Discover <input type="checkbox"/> AMEX <input type="checkbox"/> Other _____
Cardholder Name (as shown on card):	_____
Card Number:	_____
Expiration Date (mm/yy):	_____ Security Code: _____
Billing Address:	_____

I, \_\_\_\_\_, authorize Mantra Mental Health, LLC to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account. I agree to provide updated card information promptly if this information becomes invalid or card is declined

\_\_\_\_\_  
Customer Signature

\_\_\_\_\_  
Date