## **PSYCHIATRIC SERVICES OF AMERICA**

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## **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 cancelled.

Credit Card Information					
Card Type:	□ MasterCard	□VISA	□ Discover	□ AMEX	
	□Other				
Cardholder Name (as shown on card):					
Card Numbe	r:				
Expiration Date (mm/yy):			CVV Number(on back):		
Cardholder ZIP Code (from credit card billing address):					
			ric Services of America	a to charge my credit	
Patient Name		Date of	f Birth		