MATRIX

INTEGRATED PSYCHOLOGICAL SERVICES
EMPLOYEE ASSISTANCE PROGRAMS INC.

Credit Card Charge Authorization

DATE: _____

I, _____ authorize Matrix

Psychological Services to charge my Credit Card Account for any amount owed.

MasterCard ____ Visa____ Discover_____ American Express_____

Account # _____

Card Expiration Date: _____ verification code: _____

Address: (digits only) _____ Zip code: _____

Patient Name _____

_____

Signature Date

This authorization expires in 1 year from origination date.