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Date: _____

Patient: _____

PLEASE FILL IN ALL REQUESTED INFORMATION BELOW

CARDHOLDER'S NAME: _____

CREDIT CARD BILLING ADDRESS: _____

PHONE NUMBER _____

CREDIT CARD: MASTERCARD___ VISA ___ AMERICAN EXPRESS ___ DISCOVER___

CREDIT CARD
NUMBER: _____

EXP.DATE: _____ CVV#: _____

I HEREBY AUTHORIZE COMPANY NAME TO CHARGE MY CREDIT CARD ACCOUNT FOR DEDUCTIBLES, CO-PAYS, CO-INSURANCE, LATE CANCELS AND NO SHOW FEES.

CARD HOLDER'S
SIGNATURE: _____

DATE: ___/___/_____

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