MINDSPRING HEALTH

49B Lenox Pointe NE, Atlanta, GA 30324
404-333-8829 (P) 800-676-6864 (F)
info@mindspringhealth.com

Credit Card Authorization Form

Cardholder Information

Name

Billing Street Address

City **State**

Postal Code **Country**

Email **Direct Telephone**

I hereby affirm that I am the owner of the below referenced credit card and that my name is listed on the front of the credit card.

I hereby authorize Mindspring Health Inc. to charge my credit card (listed below) in the amount of each session for payment of services.

Account Holder Signature

Credit Card Information

Credit Card Type:

MasterCard	Visa	American Express
Discover Card	HSA	

Number

Expiration Month **Expiration Year** **Security Code**

Cardholder Signature **Date (MM/DD/YYYY)**

Confidentiality Notice:

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