



Mindspring Health Inc.
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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 ____ / ____ / ____

Confidentiality Notice:

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