



**Mindspring Health Inc.**  
1074 Ponce De Leon Ave NE  
Atlanta, GA 30306  
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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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