



Mindspring Health Inc.
1074 Ponce De Leon Ave NE
Atlanta, GA 30306
404-333-8829 (P)
980-495-8849 (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 ____ / ____ / ____

Confidentiality Notice:

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