



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:

Warning: UNAUTHORIZED VIEWING OR USE OF THIS WRITTEN CORRESPONDENCE COULD BE A VIOLATION OF FEDERAL AND STATE LAW.
This document contains confidential information, which is legally privileged; the information is intended only for the use of the recipient. You are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this document is strictly prohibited. If you have received this correspondence in error, please immediately notify the sender by telephone to arrange for the return of the original documents.