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 ___ /___ / _____