Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us at 678.996.5903 or admin@atlpsychiatrist.com.
This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I,_____, authorize Tamara Weiss, M.D. to charge my credit card above for agreed upon purposes. I understand that my information will be saved to file for future transactions on my account.

_____ _____
Client Signature Date