THE OCD & ANXIETY CENTER
1100 Jorie Blvd. Suite 132 Oak Brook, IL 60523 630-522-3124

Authorization for Credit Card Payment of Fees to The OCD & Anxiety Center

I, _____ authorize the payment of fees for _____
(your name) *(patient's name)*

to The OCD & Anxiety Center.

I authorize the following:
(Please check all that apply)

- ☐ Payment of my balance in full
- ☐ Payment of my balance whenever I forget a check or cash payment at time of session

Credit Card Information

Card type (please check) ☐ Visa ☐ MasterCard ☐ Discover

Account number: _____

Expiration Date: _____

CVV Code: _____

Billing address for above card information:

_____

_____

_____

Signed: _____ Date: _____

It is the responsibility of the patient and the responsible party or parties to notify the billing department at The OCD & Anxiety Center if the credit card listed on this form is canceled or stolen. If there is an issue with the above listed credit card number at time of billing, the parties listed above will be notified in writing and will have five business days to provide a new valid credit card number to be kept on file.