



Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

| Credit Card Information | | | | |
|---|--------------------------------------|-------------------------------|-----------------------------------|-------------------------------|
| Card Type: | <input type="checkbox"/> MasterCard | <input type="checkbox"/> VISA | <input type="checkbox"/> Discover | <input type="checkbox"/> AMEX |
| | <input type="checkbox"/> Other _____ | | | |
| Cardholder Name (as shown on card): _____ | | | | |
| Card Number: _____ | | | | |
| Security Code: _____ | | | | |
| Expiration Date (mm/yy): _____ | | | | |
| Cardholder ZIP Code (from credit card billing address): _____ | | | | |
| Client name(s) _____ | | | | |
| Email address for receipts: _____ | | | | |

I, _____, authorize Delaware Psychological Services and Associates to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

Customer Signature

Date