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: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Patient Name_____ Name on Card: _____
Card Number: _____
Expiration Date (mm/yy): _____ CVV_____
Cardholder ZIP Code (from credit card billing address): _____

I hereby authorize Riverview Psychiatric Medicine, PC d/b/a Clearwave Psychiatry and TMS Medical of the Hudson Valley, PC d/b/a Clearwave TMS Medical to keep my signature on file and charge the provided credit card for services rendered.

_____ _____

Signature Date