Levin & Zangrillo, P.C.
MENTAL HEALTH SERVICES

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 _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yyyy): _____ CVV _____
Cardholder ZIP Code (from credit card billing address): _____
Cardholder Email address: _____
Patient Name: _____ Date of Birth: _____
Other information:

I, _____, acknowledge and authorize Levin & Zangrillo, PC to charge my debit/HSA/credit card above for agreed upon services not covered by insurance. I understand that my information will be saved to file for future transactions on my account. I understand that charges for my co-payments, relevant deductibles, and billable broken appointments will be charged on the date of service or soon thereafter.

_____ _____

Cardholder Signature Date

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