CREDIT CARD AUTHORIZATION FORM

I authorize Triangle Wellness & Recovery PLLC to charge the following credit card for services and fees for ____________________________________ (Patient Name - Printed) as stated and agreed upon in the Triangle Wellness and Recovery PLLC Financial Agreement.

I understand that my information will be securely saved on file by Square Capital, LLC for future transactions.

I may cancel this authorization at anytime by contacting Triangle Wellness and Recovery PLLC. 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 billing address)	
CVV / CVV 2	
Email	

____

Cardholder Signature — Date

____

Cardholder Name - Printed — Relationship to Patient (if not self)

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