Tele-Medicine & Tele-Psychiatry & Tele-Substances Abuse Treatment

Authorization for Credit Card Use

PRINT AND COMPLETE THIS AUTHORIZATION AND RETURN
All information will remain confidential

Name on Card: _____

Billing Address: _____

_____

Credit Card Type: _____Visa _____Mastercard ____Discover_____AmEx

Credit Card Number: _____

Expiration Date: _____

Card Identification Number: _____ (last 3 digits located on the back of the credit card for Visa Card)

Card Identification Number: _____ (4 numbers in front of the card for American Express)

I authorize **DrGmed, Inc.** to charge the amount per session to the credit card provided herein. I agree to pay for this purchase/services in accordance with the issuing bank cardholder agreement.

Cardholder – Please Sign and Date

Print Name: _____

Date: _____

Signature: _____