Biltmore Counseling & Psychotherapy Center

Michael L. McGowan, Psy.D., MA, MBA

Clinical Psychologist

Bank / Credit Card Authorization Form

Bank / Credit Card Co. Name

MC VISA DISC Expiration Date:

Credit Card Number:

CVS #:

Card Owner Name:

Card Owner Address:

This letter authorizes Dr. McGowan (Merchant) to debit the above account for monthly office fees and services on the due date, for office located at 8426 E Shea Blvd, Scottsdale AZ 85260:

This authorization is effective as of the date listed below and shall continue until lease expires or notified in writing.:

Dated this ____________________ day of ____________________, 20______________

Card Owner Signature:

Card Owner Printed Name: