Clear Mind Therapy
9141 Cypress Green Drive, Ste 1 | Jacksonville, FL 32256
Phone: 904-733-7333

Name of Patient:	
DOB:	
First Name (as it appears on card)	
Last Name (as it appears on card)	
Relationship to patient:	
Credit Card Type: □ VISA □ MASTERCARD □ AMEX □ Discover □ Other ________________________	
Credit Card Number:	
Expiration Date:	CCV Code:
Billing Address:	
Billing City, State:	
Zip Code:	
Phone Number:	

I hereby authorized Clear Mind Therapy to charge this credit/debit card for any and all payments, patient responsibility portions of insurance explanations of benefits (if applicable), fee for the completion of any forms and/or letters I request and missed/no-show or late appointment fees.

I certify that I am an authorized signer on this card and that the credit card number and signature below are the same as those on file with the credit card issuer. I authorize Clear Mind Therapy to issue a receipt for each transaction to the email address provided on this application.

____

Card Holder Signature Date