Kevin M. Harrington, Ph.D.
Licensed Psychologist
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Credit Card Pre-Authorization Form

I authorize Dr. Kevin Harrington to keep my signature on file and to charge the credit card selected below for the following:

- **Balance remaining after claim(s) is(are) resolved not to exceed $_____for:**
  - This consultation only
  - All consultation this calendar year
  - All consultations from _____to_____
    (Date) (Date)
- **Recurring charges of $_____to be charged every_____**
  (Frequency)
  - From_____to_____.
    (Date) (Date)

Charges for the following family members:

_____ _____

(Authorized family member) (Authorized family member)

Patient Name:_____

Cardholder Name:_____

Cardholder Address:_____

City:_____State:_____ Zip:_____

Credit Card Number:_____Exp. Date:_____

Cardholder Signature:_____Date:_____