

**PRE-AUTHORIZED HEALTH CARE FORM**

**PERMISSION TO CHARGE SERVICES**

**Dyer Bilgrave, PhD**

I authorize Dyer Bilgrave to keep my signature on file and to charge my account for services not paid at time of service. I understand that this form is valid for 4 years unless I cancel the authorization through written notice to the health care provider.

Patient's Name: \_\_\_\_\_

Card Holders Name: \_\_\_\_\_

Card Holders Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

American Express    VISA    MasterCard

Account Number: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Three digit verification code on the back of your card: \_\_\_\_\_  
(on American Express, this code is 4 digits and on the front)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_