

HENRY WOODWORTH, M.D., P.C.

reco \triangle s + ru \circ ctive psychiatry

for a sustainable consciousness

143 CADYCENTRE, SUITE 302, NORTHVILLE, MI, 48167

OFFICE: 248.348.0333

FAX: 248.348.2333

drwoodworth@gmail.com

CREDIT CARD AUTHORIZATION

Client Name _____

Name (as it appears on credit card) _____

Billing Address _____

City _____ State _____ Zip Code _____

VISA _____ Mastercard _____

Credit Card Number _____ Exp date _____ 3 digit security code _____

I authorize Henry Woodworth, MD, PC, to bill the above credit card for professional services for the above-named client, including, but not limited to, office appointments, Skype appointments, extended telephone consultations, and requested written documents. I also authorize Henry Woodworth, MD, PC, to bill the above credit card for returned checks and associated fees.

I further authorize Henry Woodworth, MD, PC, to bill the above credit card for the full charge of my appointment if I do not give at least 48 business hours notice of cancellation or if I do not appear for my appointment.

Signature of card holder _____ Date _____