

**PRE-AUTHORIZED HEALTH CARE FORM
PERMISSION TO CHARGE SERVICES**

Lara C. Wrigley, Psy.D

I authorize Lara C. Wrigley 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: _____

() Am. Ex. () VISA () MasterCard

Account Number: _____ Exp. Date: _____

Three digit verification code on the back of your card: _____
(on Am Ex this code is 4 digits and on the front)

Signature: _____ Date: _____