

Philip Burke, PhD

Licensed Clinical Psychologist

West County Medical Center
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(618) 684-8700

CREDIT CARD AUTHORIZATION

Client Name: _____
Last (*print*) First Middle Initial

Cardholder Name: _____
Last (*print*) First Middle Initial

I authorize Philip Burke, PhD, to charge for professional services to the above named client as follows:

(cardholder initials)

_____ This visit only, for the amount of \$_____

_____ All visits over the next _____ months, beginning ____/____/____,
not to exceed \$_____ in total.

_____ Recurring charges, date(s) of service from ____/____/____ to ____/____/____, not to exceed
\$_____ in total,
____ monthly, ____ semi-monthly, ____ weekly, ____ per visit.

_____ Other: _____

Type of card: VISA___ MASTERCARD___ AMEX___ DISCOVER___

Card Number: _____ - _____ - _____ - _____

Expiration Date: ____/____/____ **Security Number** (on back of card): _____

Card holder's billing address for monthly card statements:

Street/apt/floor City State Zip

Card holder's signature: _____ **Date:** _____

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