



Compassionate Affordable Treatment

1811 North Raymond Avenue, Pasadena, California 91103
 Telephone: (626) 345-9992 Fax: (626) 345-9995
 www.pasadenarecoverycenter.com

CREDIT CARD BILLING AUTHORIZATION FORM

ACCOUNT HOLDER NAME:	
CREDIT CARD TYPE <small>(Please check one):</small>	Visa <input type="checkbox"/> Master Card <input type="checkbox"/> American Express <input type="checkbox"/> Discover <input type="checkbox"/>
Issuing Bank:	
Credit Card Number:	
Enter CVC Number:	(3 digits from back of card or 4 digits from face of card)
Expiration Date:	
Billing Address:	
City:	
State/Province:	
Zip/Postal Code:	
Country:	
Phone Number:	
Fax Number:	

Bill my credit card for the following Amount:	US \$ _____
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Account Holder agrees that all information provided is accurate and complete. Account Holder also acknowledges that all services may be immediately terminated if any charges are declined or charge backs are claimed against any outstanding amount due to Pasadena Recover Center.

**ACCOUNT HOLDER AGREES TO NO CHARGE BACKS OR REFUNDS
 ALL SALES ARE FINAL.**

The undersigned is the duly authorized Account Holder and authorizes the above charges pursuant to the terms set forth above.

Authorized Signature: _____ **Date:** _____