Aurora Psychiatric Associates
120 Greenwich Avenue, 3rd Floor
Greenwich, CT 06831

Credit Card Payment Authorization Form

The charge will show on your bill as Aurora Psychiatric Associates.

Name of Patient____

Name on Credit Card____

Billing Address for Card Holder:

____

City__________________________. State________ Zip Code_______________

Credit Card #____

Expiration_______________ Security Code___________

Signature of Card Holder____

Date_____________________________

_______Keep card on file for auto-payments