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Electronic Payment Form

Please complete this form with the credit card or debit card you'd like me to charge for services rendered through my practice. I accept VISA, MASTER CARD, or DISCOVER. This information will be stored securely in your clinical file, and may be changed at any time upon request.

Client's Name: _____

Client's Date of Birth: _____

Card Type (circle one): VISA MASTER CARD DISCOVER

Card Number: _____

Expiration Date: _____

CCV: _____

Account Holder's Name: _____

Billing Address: _____

_____

Please read the following statements and initial beside them:

_____ I consent to having this credit/debit card charged for all services rendered through this psychology practice.

_____ I understand that I will be charged a full session fee for no-shows and late cancellations. If I wish to cancel an appointment, I must do so 24 hours in advance to avoid the cancellation fee.

_____

Signature of Client or Legal Guardian Date