



ELECTRONIC PAYMENT AUTHORIZATION

Please complete the following information. Session fees for all clinical treatment will be deducted from the account designated on this form. Forms of payment accepted: Visa, MasterCard, Discover, and E-Checks. This form will be securely stored in your clinical file and may be updated upon request at any time.

CLIENT INFORMATION:

Client Name: _____ DOB: _____

Social Security Number (Responsible Party): _____

Responsible Billing Party Name (as shown on Credit Card/Account): _____

Billing Address (as registered with Credit Card Company/Bank):

Mobile Number: _____ Home Phone Number: _____

Email: _____

FORM OF PAYMENT:

Check One: Credit/Debit Card: _____ E-Check: _____

ACCOUNT INFORMATION:

Card Type (Visa, MasterCard, or Discover): _____

Card#: _____

Expiration Date: _____

Three Digit Card Code (Located on Back of Card): _____

-OR-

Bank Name: _____

Checking Account #: _____ Routing #: _____

Client Signature

Date