ELECTRONIC PAYMENT AUTHORIZATION

Please complete the following information.
Payment by check or cash is required at the beginning of each session.

However, Credit Card or Debit Card Information is required to set up your electronic billing through my billing service.

If you choose Visa, MasterCard, Discover, and E-Checks as your primary form of payment, an additional surcharge of $7.50 per transaction will be added.
All missed appointments and late cancellations according to my cancellation policy, will be deducted from your Credit/Debit Card, for the full session fee.
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: __________

***ACCOUNT INFORMATION*:**

Name on Account:_______________________________

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

Card#:____

Expiration Date:___________________

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

I understand and have read the financial policies and cancellation policies and I agree to those terms.

_____________________________________ _____________________________

Client Signature **Date**