ELECTRONIC PAYMENT AUTHORIZATION

Please complete the following information. Session fees for all clinical treatment will be deducted from the account designated on this form. (This includes balances that your insurance does not cover, but for which insurance says you are responsible.) Forms of payment accepted: Visa, MasterCard and Discover. This form will be securely stored in your clinical file and may be updated upon request at any time.

Client name:_____

Responsible billing party name (if different):_____

Billing address:

_____
_____
_____

Account information:

Card type: _____
Card #: _____
Expiration date: _____

_____ _____
Client Signature Date