Credit Card Agreement

Electronic Payment Authorization

Please indicate the form of payment you wish to use for any services rendered through this practice. The following forms of payments are accepted: Visa, MasterCard, American Express, and Discover. This information will be securely stored in your clinical file and may be updated upon request at any time.

Contact Information:

Client Name:_____ Date of Birth _____

Address:_____ City:_____ State:_____

Home Number:_____ Cell Number:_____

Email:_____

Payment Type: ____ Visa ____MasterCard ____American Express ____ Discover

Card Number: _____

Expiration Date: _____

Security Code (3 digit number on back of card. For American Express, four digit number on front of card):_____

Zip Code to which the credit card is billed:_____

Account Holder Information:

Please indicate the name and address associated with the credit card or bank account you wish to use.

Name:_____

Address:_____ _____City:_____ State:_____

Signature of Client or Legal Guardian:_____

Date:_____

Please be aware that there will be a 3% courtesy charge added to credit card transactions. Thank you: