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ELECTRONIC PAYMENT AUTHORIZATION

Please indicate the form of payment you wish to use for any services rendered through this practice. The following forms of payment 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: _____ Zip: _____

Home Number: _____ Mobile Number:_____

Email:_____

Credit/Debit Card Information:

Card Type (circle one): Visa MasterCard Discover Amex

Card Number: _____

Expiration Date: _____ Security Code (on back of card or for Amex 4 digit code on front): _____

Account Holder Information:
Please indicate the name and address associated with the credit card you wish to use.

Name: _____

Address: _____

City_____ State: _____ Zip: _____

_____ _____

Signature of Client or Legal Guardian **Date**

Please return this form to your therapist