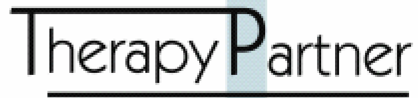

ELECTRONIC PAYMENT AUTHORIZATION

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**

Please return this form to your provider