

## ELECTRONIC PAYMENT AUTHORIZATION

Please indicate the form of payment you wish to use for any services rendered through this practice. This information will be securely stored in your clinical file and may be updated upon request at any time.

### Client Information:

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Number: \_\_\_\_\_ Mobile Number: \_\_\_\_\_

Email: \_\_\_\_\_

Therapist Name: \_\_\_\_\_

### Credit/Debit Card Information:

Card Type (circle one):      Visa      MasterCard      AMEX      Discover

Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

CUV (last 4 on back): \_\_\_\_\_

### Card Holder Information:

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

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

\_\_\_\_\_  
Signature of Cardholder

\_\_\_\_\_  
Date