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PERMISSION TO CHARGE CREDIT CARD

Whenever check/cash payment is not provided at the time of service, please charge fees associated with the following patient. *This includes charges Telehealth and for missed sessions not cancelled within 24 hours.

Name of Patient:

____

Name on Credit/Debit Card:

____

VISA/Master/Discover Card/AMEX - Enter entire credit card number:

____

Billing Address on Card:

(Street)____

(City/State/Zip)____

Expiration Date of Card: ___________________________

CVC Code on back of card (on front on AMEX):______________________________

Cardholder Signature: _________________________________ Date: _____________