



## 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