PEDIATRIC PSYCHOLOGY
ASSOCIATES

Credit Card Payment Consent Form

Patient Name _____

Print Last *First* *Middle Initial*

Name on Card if different _____

I authorize *Pediatric Psychology Associates* to charge my credit card for professional services as follows:

Initial

_____ This visit only, for the amount of $ _____ .

_____ Recurring charges, date(s) of service _____ /_____ /_____ to

_____ /_____ /_____, not to exceed $_____ per visit.

_____ For Psychological Testing $_____ at initial appointment, $_____

at time of first testing appointment, $_____ at last testing appointment.

_____ To charge my card for outstanding balances on my account over 30 days.

Type of Card: □ Visa □ MasterCard We do not accept AMEX or Discover

Credit Card Number _____ - _____ - _____ - _____

Expiration Date _____ CVV Number _____ 3-digit number in reverse italics on the **back** of the credit card

Card Holder's Billing Address for Credit Card Statements

_____

Street City State Zip

Best Contact Phone Number if any questions:_____

Card Holder Signature _____ Date ____ /_____ /____