PSYCHOLOGY
CONSULTANTS ASSOCIATED

Name: _____ Date:_____

Email: _____

Credit Card Easy Pay Consent

I authorize Psychology Consultants to charge my credit card for balances and co-pays due, not to exceed $ _____ per month. Psychology Consultants may charge my card on the _____ day of every month or after every visit. Please initial below:

_____One time per month _____After each visit

I understand this form is valid for one year from the date above.

Cardholder Signature: _____

Patient Information:

Patient Name: _____

VISA MASTERCARD DISCOVER AMERICAN EXPRESS

Credit Card Number: _____

Expiration Date: _____ V Code:_____