PEDIATRIC PSYCHOLOGY
ASSOCIATES

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Credit Card Payment Consent Form

Patient Name:____

Parent/Guardian:____

Please charge my credit card (check one):

______ One time only in the amount of $_________

______ Recurrent charges after every service and for any outstanding balances.

Type of Card: □ Visa □ MasterCard □ AMEX

Cardholder's Name (as printed on card):____

Credit Card Number ___________ - ___________ - ___________ - ___________

Expiration Date ____________ CVV Number _________ 3-digit # **back** of the card (AMEX 4-digit # front of card)

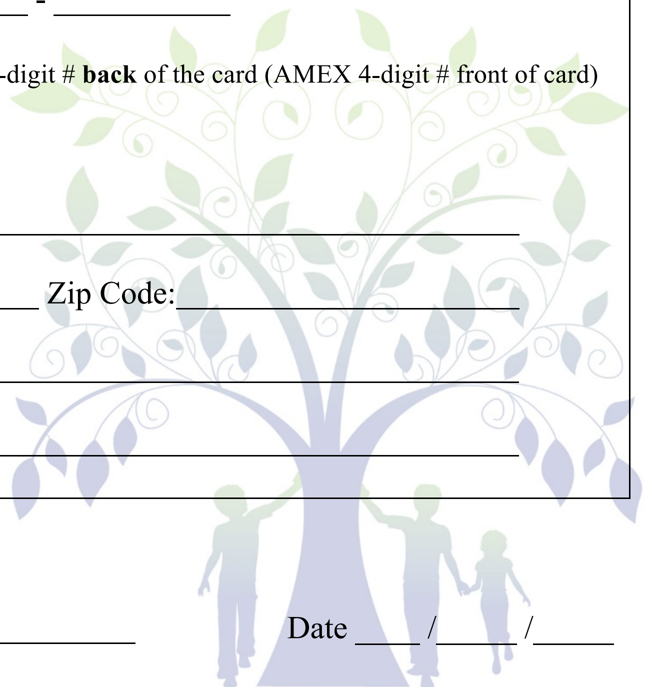
Card Holder's Billing Address for Credit Card Statements:

Street Address:____

City:________________________________ State:_____________ Zip Code:______________________

Best Contact Phone Number :____

Best Contact Email address:____



Signature ____ Date ____ /_____ /_____