



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 ____ / ____ / ____