ELECTRONIC PAYMENT AUTHORIZATION

Please indicate the form of payment you wish to use for any services rendered through this practice. The following forms of payment are accepted: **Visa, MasterCard,** and **Discover.** This information will be securely stored in your clinical file and may be updated upon request at any time. Please be aware that transactions will appear as "Therapy Partner" on your bank or credit card statement.

Contact Information:

Client Name: ____ Date of Birth: _____________________

Address: ____________________________ City_____________________ State: ________ Zip: _________

Home Number: ______________________________ Mobile Number: ______________________________

Email: ____

Credit/Debit Card Information:

Card Type (circle one): Visa MasterCard Discover

Card Number: ____

Expiration Date: _______________

Account Holder Information:

Please indicate the name and address associated with the credit card account you wish to use.

Name: ____

Address: ____________________________ City_____________________ State: ________ Zip: _________

____ ______________________

Signature of Client or Legal Guardian **Date**

Please return this form to your therapist