Credit/Debit Card Payment Consent Form

Patient Name _____

Name on Card if different _____

I authorize Angela DeCraene, MA, LCPC
to charge my credit/debit card for professional services as follows:

This visit only, for the amount of $ _____ .

All visits in the next 12 months, beginning _____ /_____ /_____,
not to exceed $ _____ total.

Recurring charges, date(s) of service _____ /_____ /_____ to
_____ /_____ /_____, not to exceed $ _____,

____ monthly, ____ semimonthly, ____ weekly, ____ per visit.

To charge my card for the balance of fees not paid by my insurance company within 90 days, as indicated above.

Visa, MasterCard, Discover.

Type of Card:_____
Card Number _____ - _____ - _____ - _____,
CVV Number _____A 3-digit number in reverse italics on the **back** of the credit card
Expiration Date _____

Card Holder's Billing Address for Credit Card Statements

_____

Street *City* *State* *Zip*

If I have questions about these charges, I agree to contact my provider. I agree that I will not pursue a refund directly through my credit/debit card company, bank, or financial institution. If any of my actions yield a chargeback for any reason, I agree to pay any and all penalty fee(s) incurred by my provider.

Card Holder Signature _____

Date ____ /_____ /____