Credit/Debit Card Payment Consent Form

Patient Name _____
Print Last First Middle Initial

Name on Card if different _____

I authorize Kate Ainslie, PsyD to charge my card for professional services as follows:

(Initial)

_____ This visit only, for the amount of $_____.

_____ All visits, beginning _____ /_____ /_____

Type of Card: □ VISA □ MasterCard □

Exp. Date _____

Card Number _____ - _____ - _____ - _____

Card Holder's Billing Address

_____
Street City State Zip

_____
Phone number

Card Holder Signature _____ Date ____ /____ /____