AGREEMENT FOR CREDIT CARD PAYMENTS

Please complete the following information in its entirety and sign for consent to use the credit card for payment of services rendered and <u>any outstanding balances</u>. Please provide the names of all clients whom you would like this credit card to be filed under. This information will be stored in a secured/locked cabinet.

Client Name: ________________________________ DoB: __________

Client Name: ________________________________ DoB: __________

Client Name: ________________________________ DoB: __________

Credit Card Type: (please circle one) Master Card -or- Visa -or- Discover-or-HSA/Flex Spending

Credit Card (16-digit #): ____

Expiration Date (mm/yy): ________________

Security Code (3-digit): _________

Please provide the best contact number where you can be reached:

Phone Number (with area code): ______________________

I agree that all the information provided is accurate. I consent to provide my credit card information for the use of paying for services rendered (ie: therapy, testing, medication management, phone sessions, and groups) at Behavioral Psychology Associates.

<u>**PLEASE NOTE THAT BY SIGNING THIS AGREEMENT, YOU AUTHORIZE BEHAVIORAL PSYCHOLOGY ASSOCIATES P.C. TO USE THIS CREDIT CARD FOR ANY OUTSTANDING BALANCE ON YOUR ACCOUNT**</u>

X ____
Print name of cardholder

X ____ ______________
Signature of the cardholder/authorized responsible party Date (mm/dd/yy)