



Credit Card Payment Consent Form

▶ Name:

First Middle Initial Last

▶ Name on card if different:

First Middle Initial Last

▶ I authorize Abbeyfield Psychotherapy, Inc to charge my credit card for professional services as follows:

Initial all that apply

- a. All visits in the next 12 months, beginning ___/___/____.
b. Recurring charges for date(s) of service ___/___/____ to ___/___/____,
\$_____ monthly, \$_____ semi-monthly,
\$_____ weekly, or \$_____ per visit.
c. To charge my card for the balance of fees not paid for or covered by my insurance company within 180 days of the denial of payment.
d. To charge my card for the balance of fees not paid 180 days from termination of service(s).
e. To charge my card for any missed appointments or appointments cancelled within 24 hours for the fee of \$75
f. To charge my card for any copays not collected at time of service.

__X__ g. I understand that a \$3.00 convenience fee (per transaction) will be added to any amount charged.
Abbeyfield and/or my therapist do not keep this fee and it is paid to help maintain this service.

▶ Type of card: Visa MasterCard AMEX Expiration date of card: ___/___/_____

▶ Credit card number: _____ Security code: _____

▶ Card holder's billing address for credit card receipts:

Street City State Zip

▶ Card holder's email address for credit card receipts: _____

▶ Cardholder's Signature:

Signature Date