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 when the card is not present at transaction. Abbeyfield and/or my therapist do not keep this fee and it is paid to the credit card processor 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 Required for Processing**

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

► Cardholder's Signature:

_____

Signature Date