NEXT STEP PSYCHOLOGY PLLC

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CREDIT CARD AUTHORIZATION

DATE :	PATIENT NAME:	OFFICE ACCOUNT NO.:

CREDIT CARD AUTHORIZATION

Credit Card Holder's Name:
(Please print as it appears on the card)

MAILING ADDRESS WHERE CREDIT CARD STATEMENT IS SENT:

Street Address: City: State: Zip Code:

Home Phone: Email:

_____Initial ***Ihereby authorize charges to my credit card for services rendered by Next Step Psychology that are not paid directly in cash or check.***

_____Initial ***I understand that late or non-cancelled (no show) visits will be charged to my credit card.***

_____Initial ***I understand that it is my responsibility to notify office personnel if I change my credit card companies and/or numbers.***

_____Initial ***I will update the expiration date of my credit card when necessary.***

CREDIT CARD INFORMATION

Credit Card Company:
□ Visa □ Master Card □ Other _____

Credit Card Number:
_____ - _____ - _____- _____

Credit Card Three Digit Security (CCV#):
_____

Expiration Date:
_____ / _____

Signature: Date: