Bill Farrand, LCPC

CREDIT CARD AUTHORIZATION FORM

Please indicate the form of payment that you authorize for any services rendered through this practice. Information is securely stored in your clinical file and may be updated upon request at any time.

PATIENT / CLIENT INFORMATION:

NAME: _____

DATE OF BIRTH: _____ / _____ / _____
(Month) (Day) (Year)

ADDRESS:
_____
(Street and Number)

_____ _____ _____
(City) (State) (Zip Code)

CELL PHONE: _____

HOME PHONE: _____

EMAIL: _____

CREDIT / DEBIT CARD INFORMATION:

Card Type: ☐ Visa ☐ Mastercard ☐ AMEX ☐ Other: _____

Card Number: _____ **Expiration Date:** _____

CARD HOLDER INFORMATION:
Please indicate the name and complete address associated with this debit or credit card you wish to use for payment of services.

NAME:
_____

ADDRESS:
_____
(Street and Number)

_____ _____ _____
(City) (State) (Zip Code)

_____ _____
SIGNATURE OF PATIENT / AUTHORIZED CARD HOLDER **DATE**