



ELECTRONIC PAYMENT AUTHORIZATION

Please indicate the form of payment you wish to use for any services rendered through this practice. The following forms of payment are accepted: **Visa, MasterCard, Discover** and **Electronic Checks**. This information will be securely stored in your clinical file and may be updated upon request at any time. Please be aware that transactions will appear as "Therapy Partner" on your bank or credit card statements.

Contact Information:

Client Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Number: _____ Mobile Number: _____

Email: _____

Payment Type (check one):

Credit/Debit Card: _____ E-Check: _____

Credit/Debit Card Information:

Card Type (circle one): Visa MasterCard Discover

Card Number: _____

Expiration Date: _____ Three-Digit Card Code (located on back of card): _____

-or-

Electronic Check Information:

Bank Name: _____

Routing Number: _____ Account Number: _____

Account Holder Information:

Please indicate the name and address associated with the credit card or bank account you wish to use.

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Signature of Client or Legal Guardian

Date

Please return this form to your therapist