ELECTRONIC PAYMENT AUTHORIZATION

Please complete the following information and return this form to your provider. Session fees for all clinical treatment will be deducted from the account designated on this form. Forms of payment accepted: Visa, MasterCard, Discover, Check and cash. This form will be securely stored in your clinical file and may be updated upon request at any time.

PROVIDER NAME: JUDY CHAMBERLIN LCSW

Client Information:

Client Name: _____ Date of Birth: _____

Address: _____ City_____ State: _____ Zip: _____

Home Number: _____ Mobile Number: _____

Email: _____

Cardholder Information: ☐ Check box if same as client information

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

Name: _____

Address: _____ City_____ State: _____ Zip: _____

Email: _____

_____ _____

Cardholder Signature Date

A statement will be emailed to you on the 5th of the month from Therapy Partner for dates of service for the month prior.

☐ Please check here If you would like **to opt-out of receiving email statements**.
If you do NOT want to receive anything via email, please leave the email info blank.

Please note that we will NEVER share your email information with outside parties other than Therapy Partner for the sole purpose of sending automatic statements each month.

PREFERRED FORM OF PAYMENT:

Check One: Credit/Debit Card: ☐ Check/Cash ☐

ACCOUNT INFORMATION:

Card Type (circle one): Visa MasterCard Discover

Card Number: _____

Expiration Date: _____

_____ _____

Client Signature **Date**