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 Psy.D.

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

I authorize the use of this card for all services and fees at the time they are rendered for the above client. I understand that this form authorizes my provider to charge this card for varying session types, across multiple dates of service. *By authorizing use of this card, and signing this electronic payment authorization form, I certify that I am the cardholder and my signature below authorizes each individual charge for all dates of service.

_____ _____

Cardholder Signature **Date**

Payments are processed by Therapy Partner.
Therapy Partner is a registered ISO/MSP of Fifth Third Bank, Cincinnati, OH and HSBC Bank USA National Association, Buffalo, NY.

PREFERRED FORM OF PAYMENT:

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

ACCOUNT INFORMATION:

Card Type (circle one): Visa MasterCard Discover

Card Number: _____

Expiration Date: _____ CVV Code _____

_____ _____

Client Signature **Date**