Credit / Debit Card Payment Consent Form

Patient Name _____

Name on Card if different _____

I authorize Valerie Correa, PsyD **to charge my card for professional services as follows:**

Initial

_____ This visit only, for the amount of $140 per session hour

_____ All visits in the next 12 months, beginning ___/___/___ not to exceed $_____ total.

_____ Recurring charges, date(s) of service ___/___/___ to ___/___/___, not to exceed $_____, _____ monthly, _____ semi-monthly, _____ weekly, _____ per visit.

_____ **To charge my card for the my overdue account balance of $ _____ to be paid in full at this time.**

☐ VISA ☐ MASTERCARD

Expiration Date _____

Card Number: _____-_____-_____-_____ DVV Number _____

Card Holder's Billing Address for Monthly Card Statements

_____

Street City State Zip

Card Holder Signature _____Date___/___/___

PLEASE HAND DELIVER, MAIL OR FAX TO DR. CORREA AT: *802 D Officer's Row*
Vancouver, Washington 98661
FAX# 360-993-5262
Charges will appear on your card statement as **Valerie Correa**

I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred. I also understand by signing and initialing this form that if no payment has been made by either me, or the insurance company in the last 90 days, my card will be charged for all outstanding balances.

_____ / ____
INITIALS / DATE