Kathryn Doheny, PsyD

Licensed Clinical Psychologist

312.409.0899 | kathryn@doheny.com

307 N. Michigan Ave Suite 802, Chicago, IL 60601

CREDIT/DEBIT CARD PAYMENT CONSENT FORM

Client Name: _____
Print First Print Last Middle Initial

Name on Card if Different: _____

Email (for receipt): _____

I authorize Kathryn M. Doheny, Psy.D. and ProfessionalCharges.com to charge my card for professional services as follows:

Initial

_____ Recurring charges, beginning with date of service and ending on last session (to be determined). Not to exceed $_____ per visit. (Fill this portion in if you are paying out-of-pocket).

_____ To charge my card for the balance of fees not paid by my insurance company. (Fill this portion in if you are paying with insurance).

Type of Card: ☐ VISA ☐ MasterCard ☐ Discover

Exp. Date: _____/_____

Card Number: _____–_____–_____–_____

DVV Number: _____ (3 digit number from back of card)

Card Holder's Billing Address for Monthly Card Statements:

_____
Street City State Zip

_____ _____
Card Holder Signature Date

Charges will appear on your credit card statement as ProfessionalCharges.com or some abbreviation of it.