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CREDIT/DEBIT CARD PAYMENT CONSENT FORM

Patient Name: _____

Print Last Print First Middle Initial

Name on Card if Different: _____

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

Please initial to acknowledge these terms

_____ All: A 3.5% convenience fee applies to all charges.

_____ For self-pay: Professional charges $_____ per session.

_____ When insurance is applied: To charge my card for the balance of fees not paid by my insurance company within 90 days, as indicated above.

Type of Card: ❑ VISA ❑ MasterCard ❑ Discover

Card Number: _____–_____–_____–_____

Exp. Date: _____/_____

CVV Number: _____ (3 digit # from back of card)

Card Holder's Billing Address for Monthly Card Statements:

_____

Street City State Zip

Card Holder Email Address: _____

An email receipt will automatically be sent from 'professional charges' at the time of billing.

_____ _____

Card Holder Signature Date

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