

Credit Card Payment Consent Form

Patient Name: _____

Name on card if different: _____

Billing Address: _____

I authorize Cadenza Center for Psychotherapy & the Arts, Inc. to charge my credit card for professional services as follows:

Initial

_____ Recurring charges (copays, weekly camp fees) not to exceed \$ _____ per visit
_____ for date(s) of service _____ to _____

_____ To charge my card for late pick-up fees as per the summer program policy.

_____ To charge my card in the amount of \$ _____ for visits missed or cancelled without the
_____ required 24 hours notice (unless it's an emergency situation).

Type of Card: Visa MasterCard Expiration Date _____

Credit Card Number - - - CVV Number
_____ _____ _____ _____
3-digits on back of card

Cardholder Signature _____ Date: _____