Credit/Debit Card Payment Consent Form

Client Name _____
Name on Card if different _____

I authorize Amanda Bevacqua, LMFT and ProfessionalCharges.com to charge my card for professional services as follows:
_____ To charge my card for the balance of fees not paid by my insurance company or myself within 90 days. This includes any no show fees. (initial on line above)

Type of Card (circle one): VISA MasterCard Discover
Card Number _____ - _____ - _____ - _____
Exp. Date _____/_____
CVV Number _____ (3 digit # from back of card)

Card Holder's Billing Address for Monthly Card Statements
_____
Card Holder E-mail Address _____
A credit card receipt that does not contain the full credit card number will be e-mailed to you at the email address above.

Card Holder Signature _____ Date ____ /____ /____