Credit Card Approval

DATE:_____ PROVIDER NAME: Stephanie Moberg, MA, LMFT

PATIENT NAME:_____ DOB:_____

TYPE (circle one): VISA MC

CREDIT CARD #_____ EXP:_____

NAME ON CARD:_____ SECURITY CODE:_____

MAILING ADDRESS ASSOCIATED WITH CARD:

_____

Street or PO Box City State Zip

PATIENT PHONE:_____

I would like to receive my credit card receipt via Email **YES NO**

Email: Email Address:_____

NOTES:_____

_____

I authorize the Stephanie Moberg to run my credit card listed above for any balance I accrue. I understand that my card will be run without prior notice to myself and that a receipt will be provided via email. If I wish to terminate my credit card payment on file, I understand that I will need to give 5 business days notice for this to take effect.

_____ _____

Patient or Guardian Signature (if patient is under 18 years of age) Date

Termination of Card on File

I am requesting that my credit card on file be removed effective:_____(Date) my card will no longer be run by the Provider listed above and I will be responsible for remitting payment in full when my bill is received. Failure to remit payment in full within 90 days may result in my account being turned over for collections.

_____ _____

Patient or Guardian Signature (If patient is under 18 years of age) Date