Credit Card Authorization and Consent

My signature below indicates that I understand and agree to assume financial responsibility for my treatment. I authorize Amy T. Corey, Ph.D. to charge my credit card automatically for debits on my account. I understand that I will not be charged now and that this card will be stored and used for charges that are my responsibility.

_______________________________________ _____________________

Client Signature Date

Credit Card Information

- ☐ Visa
- ☐ Mastercard
- ☐ Discover
- ☐ HSA
- ☐ AMEX

Cardholder's Name: ____

Credit Card Number: _____________-____________-____________-____________

Expiration Date: _____/_____ CVV: __ __ __

Billing Details

Street Address ____________________________________ Apt/Unit _________

City, State, Zip ____

Email ____