



## ELECTRONIC PAYMENT AUTHORIZATION

Please indicate the form of payment you wish to use for any services rendered through this practice. The following forms of payment are accepted: **Visa, MasterCard, Discover, American Express** and **Electronic Checks**. This information will be securely stored in your clinical file and may be updated upon request at any time. Please be aware that transactions will appear as "Therapy Partner" on your bank or credit card statement.

### Contact Information:

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Number: \_\_\_\_\_ Mobile Number: \_\_\_\_\_

Email: \_\_\_\_\_

### Payment Type (check one):

Credit/Debit Card: \_\_\_\_\_ E-Check: \_\_\_\_\_

### Credit/Debit Card Information:

Card Type (circle one):    Visa    MasterCard    Discover    American Express

Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

-or-

### Electronic Check Information:

Bank Name: \_\_\_\_\_

Routing Number: \_\_\_\_\_ Account Number: \_\_\_\_\_

### Account Holder Information:

Please indicate the name and address associated with the credit card or bank account you wish to use.

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

\_\_\_\_\_  
**Signature of Client or Legal Guardian**

\_\_\_\_\_  
**Date**

**Please return this form to your therapist**