



Client Payment Consent Form

Today's Date: _____

Client Name: (Please print) _____

Client DOB: _____/_____/_____

Name on Card (if different from above): _____

I authorize Child & Family Psychological Services, PLLC to securely store and automatically charge my card for professional services rendered under the terms of my Services Agreement with them. This authorization shall be valid from the date of signature until services/treatments are completed.

Please note: Initial charge of \$.01 will be charged to card upon adding card to patient account. Upon approval of charge, this \$.01 charged is then reversed.

I authorize CFPS, PLLC to charge up to the following limit on my securely stored credit card: \$ _____

(If no Limit is indicated above, the default will be set to \$500.00)

Type of card (circle one): Discover MasterCard Visa American Express

Exp Date: _____/_____

Cardholder's signature: _____

Date: _____