Child & Family Psychological Associates

Robert M. Brewster Ph.D. David J. Coleman, Ph.D. Geoffrey E. Putt, Psy.D.

CREDIT CARD AUTHORIZATION

FLEX/HSA DEBIT CARDS CANNOT BE PROCESSED- BILLS MUST BE SUBMITTED TO YOUR PLAN ADMINISTRATOR

Client's Name ______________________________ DOB ____________

Check One: ☐ Visa ☐ MasterCard ☐ Discover ☐ Amx

Name on Card _________________________ Amount Authorized $__________

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Billing Zip Code

Fill in below or present card for copying

Card#

|_|_|_|_|_| |_|_|_|_|_| |_|_|_|_|_| |_|_|_|_|_|

CW# These are the 3 numbers on the back of your card, in the signature line

|_|_|_|_|

Expiration Date

M |_|_|_| Y |_|_|_|

I agree to authorize all future payments for services not covered by my insurance carrier to this credit card. Authorization may be withdrawn at any time in writing. ☐ No ☐ Yes

Email Receipts? ☐ No ☐ Yes

____
Email address

____
Signature

____
Date

____
Printed Name

822 Portage Trail
330-923-9344 Cuyahoga Falls, Ohio 44221 866-248-1103 (f)
www.childandfamilypsychologists.com