



## CREDIT CARD CONSENT & AUTHORIZATION FORM

I, \_\_\_\_\_, hereby authorize Julia Barry, LMFT to keep my signature on file and to automatically charge my credit card account as indicated below:

for charges for missed or cancelled sessions, with less than 24 hours advance notice from \_\_\_\_/\_\_\_\_/\_\_\_\_ until Patient (named below) is formally discharged as a patient from the office of Julia Barry, LMFT unless I revoke such authorization in writing beforehand.

for the amount of each check that does not clear the bank, for whatever reason, plus a \$20 returned check charge per incident.

Optional:

for a single charge of \_\_\_\_\_ for Patient's initial consultation on \_\_\_\_/\_\_\_\_/\_\_\_\_ .

for recurring charges (ongoing treatments) per visit of \_\_\_\_\_ from \_\_\_\_/\_\_\_\_/\_\_\_\_ until Patient is formally discharged as a patient from the office of Julia Barry, LMFT unless I revoke such authorization in writing beforehand.

CHECK ONE:

MasterCard V code (3 digits in back): \_\_\_\_\_

Visa V code (3 digits in back): \_\_\_\_\_

American Express V code (4 digits in front): \_\_\_\_\_

A photocopy or facsimile of this signature is as valid as the original.

PATIENT NAME: \_\_\_\_\_

CARDHOLDER NAME (As printed on card):  
\_\_\_\_\_

ACCOUNT NUMBER: \_\_\_\_\_

EXPIRATION DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_



JULIA BARRY  
PSYCHOLOGIST

CARDHOLDER BILLING ADDRESS:

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Street Number

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City

Zip

CARDHOLDER SIGNATURE: \_\_\_\_\_

DATE SIGNED: \_\_\_\_/\_\_\_\_/\_\_\_\_