JULIA BARRY
PSYCHOTHERAPY

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
PSYCHOTHERAPY

CARDHOLDER BILLING ADDRESS:

Street Number

City Zip

CARDHOLDER SIGNATURE: _____

DATE SIGNED: ____/____/____