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CREDIT CARD PAYMENT RECORD and CONSENT TO TELEMENTAL HEALTH

Client Name as it Appears on Card: _____

Card Number: _____ Expiration Date: _____

Credit Card Billing Information: _____ _____ _____
Street Number Zip Code Card Type

Security Code on Card (3 or 4 numeric digits): _____

Client Signature: _____
Signature indicates that you agree to allow your therapist to make charges on your card without you present.

When you print, date, and sign your name you understand you agree to the informed consent policies on cancellations and you are authorizing me to utilize the TeleMental Health/ session charges needed for your treatment.

Description of Service (e.g., 90847)	Date of Session	Date Posted	Amount Session	Discounted Cost	Total Cost

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