The Practice of Dayna Nelson Psy.D

ELECTRONIC PAYMENT AUTHORIZATION

Please complete the following information. Session fees for all clinical treatment will be deducted from the account designated on this form. Forms of payment accepted: Visa, MasterCard, Discover, and E-Checks. This form will be securely stored in your clinical file and may be updated upon request at any time.

***CLIENT INFORMATION*:**

Client Name:_____________________________________ **DOB:**______________________

Responsible Billing Party Name (as shown on Credit Card/Account)**:**_____________________________

Billing Address (as registered with Credit Card Company/Bank)**:**

____

____

Mobile Number:________________________ **Home Phone Number:**______________________

Email:____

***FORM OF PAYMENT*:**

Check One: Credit/Debit Card: ________ E-Check: ________

***ACCOUNT INFORMATION*:**

Card Type (Visa, MasterCard, or Discover):_______________

Card#:____

Expiration Date:___________________

Three Digit Card Code (Located on Back of Card): __________

-OR-

Bank Name:___________________________________

Checking Account#:__________________________ **Routing#:**__________________________

_______________________________________ ______________________________

Client Signature **Date**

Please return this form to your provider