# Credit Card Payment Authorization

Please complete the following information if you wish to authorize credit card payments for psychotherapy services rendered by Jeffrey Kisling, Ph.D., LMFT. Session fees for all clinical treatment will be charged to the account designated on this form. This form will be securely stored in your clinical file, and may be updated or cancelled upon request at any time. **Please note that *Sq *Jeffrey Kisling* will appear on your credit card statement. The following credit cards are accepted: American Express, Discover, MasterCard, and Visa.**

**Patient Information (Please Print)**

Name: ______________________________________________

Birthdate: ______________________________________________

Social Security Number: ______________________________________

Responsible Billing Party Name: _________________________________

Billing Address (as registered with credit card company):

______________________________________________

______________________________________________

Home Phone: ______________________________________________

Mobile Phone: ______________________________________________

Email: ______________________________________________

**Account Information**

Card Type (circle one): American Express Discover MasterCard Visa

Card Number: ______________________________________________

Expiration: ___________________________ Security Code: __________

Name on Card: ______________________________________________

The undersigned hereby authorizes credit card payments for psychotherapy services rendered by Jeffrey Kisling, Ph.D., LMFT.

______________________________________________

Patient Signature/Date