Sarah Ray, Psy.D., QME
Advanced Health Care

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Credit/Debit Card Payment Consent Form

Patient Name _____

Name on Card (if different than above) _____

I authorize Sarah Ray, Psy.D. and/or her associates to charge my credit card for professional services as follows:

Please Initial

_____ I agree to pay the agreed upon amount per session. I also agree to pay a $100 no show/cancellation fee should I not call 24 hours prior to my appointment t

_____ I agree to pay my insurance co-pay as indicated by my insurance plan. For out-of-network insurances, I agree to pay any amount not covered by my plan within 90 days. I also agree to pay the full insurance allowable amount, or a maximum of $100, for the no show/ cancellation fee should I not call 24 hours prior to my appointment time. *(Fill in this portion if you are using insurance.)*

Type of Card _____ VISA ____ MasterCard ____Discover _____AMEX

Expiration Date _____/_____

Card Number _____-_____-_____-_____

DVV Number _____ (3 digit number from back of card)

Card Holder's Billing Address for Monthly Charge Statements

_____

Street *City* *State* *Zip*

Card Holder Signature _____ Date _____/_____/_____

My signature below is an acknowledgement that I understand and agree to comply with the credit card policy.

_____
Print Name of Patient

_____ _____
Signature of Patient Date