Authorization of Debit/Credit Card

Cardholder Name: _____ Date of Birth:_____

Credit Card #: _____ (Visa or MC only)

Exp. Date: _____ CVC Code: _____ Billing Zip Code: _____

I, _____, authorize my therapist at Mt. Diablo Psychological Services, to charge the credit card as named above for health services rendered to _____.

Services that may be charged to this credit card include, but are not limited to the following:

- Mental Health Assessment
- Individual Therapy
- Family Therapy
- Group Therapy
- Case Management Services
- Consultation
- Missed Session

Charges will be made at the time of service or monthly for the balance due. This agreement will expire after treatment is terminated and no further charges are incurred.

Your signature below indicates that you have read and agree to abide by the terms of this document during the course of our professional relation.

_____
Printed name of patient/parent/guardian

_____ _____
Signature of parent/guardian Date