Michele R. Barton, Ph.D.
Licensed Clinical Psychologist
Harrison, NY
O(914) 468-0816
C(914) 629-2912

CREDIT CARD AUTHORIZATION AGREEMENT

Account Holder Information:
Please indicate the name and address associated with the credit card you wish to use.

Name: _____
Print

Address: _____ City_____ State: _____ Zip: _____

Email Address where invoices may be sent: _____

Name of person authorized to use credit card if different from holder

_____
Print

I hereby permit Michael Fraser, Ph.D. to use the account on the terms and at the rates set forth herein,

$__300.00_____ per visit.

Credit Card Information:
Please indicate the form of payment you wish to use for any services rendered through this practice. The following forms of payment are accepted: **Visa**, **MasterCard**, or **Discover**. This information will be securely stored in your clinical file and may be updated upon request at any time. Please be aware that transactions will appear as "Therapy Partner" on your bank or credit card statement.

Visa _____ Mastercard _____ Discover _____

Credit Card Number: _____

Expiration Date: _____

I understand that payments will continue until I have paid in full any unpaid balance.

I may terminate this Agreement at any time, provided other payment arrangements have been set forth or my account has been satisfied in full.

If you allow someone other than yourself to use your credit card, you must promise to pay for all visits and you will be liable for all payments until satisfied in full. If someone else is using your account and you wish to end that person's privilege, you must notify me immediately in writing.

By signing this form, I agree to all the terms and conditions above and promise to perform all the obligations, requirements and duties set forth in this agreement.

_____ _____
Signature of Card Holder **Date**

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Psychological Services:

Individual/Family/Couples/Group Psychotherapy Biofeedback/Neurofeedback/Virtual Reality