PAYMENT CONSENT FORM

Name _____

Print Name as it appears on your card

Name of client if different _____

I authorize Kristen Wynns, Ph.D, PLLC (dba Wynns Family Psychology) to charge my credit card for:

Initial

_____ This visit only, for the amount of $

_____ All fees in the next 12 months, beginning

_____ To charge my card using interoffice credit card machine.

_____ I understand the WFP 48 hour cancellation policy and authorize missed appointments fees to be charged to my credit card (required).

Type of Card: Visa ____ MasterCard ____ American Express ____

Expiration Date _____

Credit Card Number: _____ - _____ - _____ - _____ CVV Number _____

Card Holder's Billing Address for Credit Card Statements:

_____

Street City State Zip

Email: _____ Phone: _____

Card Holder Signature _____ Date _____/_____/_____

The date listed on your credit card statement may be different than the actual date of service.