Joseph C. Mallet, Psy.D., P.A.
Pediatric ◆ Adolescent ◆ Family Psychology

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Credit Card Payment Authorization Form

Patient Name: _____Date of Birth:_____

Name on Card if different_____

I authorize Dr. Joseph C. Mallet to charge my credit card for professional services as follows:

For Psychotherapy Session, (Initial Consultation and follow up visits) **$180.00/hour Session**

Set Payment plan Full Payment or partial payments:
_____

To charge my card for the balance of fees.

Type of Card:

❒ Visa ❒ MasterCard ❒ American Express

Credit Card Number _____ - _____ - _____ - _____

Expiration Date _____

CVV Number _____3-digit number (or 4 Digit AMEX) in reverse italics on the back of the credit card

Card Holder's **Zip Code** for Credit Card Statements: _____

Best Contact Phone Number if any questions:

Card Holder Signature

_____ Date _____ /_____ /_____