Wendy Byrd, MA, LPC, LMFT

ELECTRONIC PAYMENT AUTHORIZATION

Please complete the following information. Session fees for all clinical treatment will be deducted from the account designated on this form. Forms of payment accepted: Visa, MasterCard, Discover, and E-Checks. This form will be securely stored in your clinical file and may be updated upon request at any time.

***CLIENT INFORMATION*:**

Client Name:_____ **DOB:**_____

Social Security Number (Responsible Party)**:** _____

Responsible Billing Party Name (as shown on Credit Card/Account)**:**_____

Billing Address (as registered with Credit Card Company/Bank)**:**

_____

_____

Mobile Number:_____ **Home Phone Number:**_____

Email:_____

***FORM OF PAYMENT*:**

Credit/Debit Card: _____

***ACCOUNT INFORMATION*:**

Card Type (Visa, MasterCard, or Discover):_____

Card#:_____

Expiration Date:_____

Three Digit Card Code (Located on Back of Card): _____

Please return this form to your provider