Annie BROGGER | mft

Credit/Debit Card Payment Consent Form

Patient Name

(Last)_____(First)_____(M.I.)_____

Name on Card if different_____

I authorize Annie Brogger, LMFT, to charge my credit/debit card for professional services as follows:

____This visit only, for the amount of $_____.

____All visits in the next 12 months , beginning _____/_____/_____.

____All visits beginning____/____/____until treatment ends.

____Recurring charges, date(s) of service ____ /____/____ to ____/____/____

____To charge my card for the balance of fess not paid.

Type of Card ____Visa ____MasterCard ____Discover

Card Number_____ - _____ - _____ - _____ CVV Number _____

Expiration Date _____

Card Holder's Billing Address for Credit Card Statements:

Street_____City_____

State_____ Zip_____

If I have questions about these charges, I agree to contact my provider. I agree that I will not pursue a refund directly through my credit/debit card company, bank, or financial institution. If any of my actions yield a chargeback for any reason, I agree to pay any and all penalty fee(s) incurred by my provider.

Please send receipt by email or text to: _____

Receipt will come from annie@anniebroggermft.com Check junk mail folder.

Card Holder Signature_____

Date_____/_____/_____