Credit Card Payment Consent Form

Patient/Professional Name _____
Print First *Middle Initial* *Last*

Patient or Billing Address :_____

Name of Financially Responsible Party(FRP) if Different from Above

_____

Address of FRP

_____

Name on Card if different _____

I authorize *Andrea B. Barbour, MA, LMFT* to charge my credit/debit card for professional services as follows:

- ❑ **Psychotherapy**
- ❑ **Consultation**
- ❑ **Administration Fees**
- ❑ **Late or No Show Cancelations**
- ❑ **For the balance of fees not otherwise paid**
- ❑ **Professional Training and/or Consultation**

The amounts charged are in accordance with the Fee Agreement signed by both the Patient and the Financially Responsible Party. For Professional Training and/or Consultation please put the name of the training (or put consultation) here :_____

Type of Card: ☐ Visa, ☐ MasterCard, ☐ Discover ☐ HSA

Expiration Date _____

Credit Card Number _____ - _____ - _____ - _____, DVV Security Number _____
Card Holder's Billing Address for Credit Card Statements

_____
Street *City* *State* *Zip*

Email (for receipt):_____

Card Holder Signature _____, Date ____ /_____ /____

Please return this form to:

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(O) 812-764-4931 (F) 317-875-1060 andreabarbourmft@gmail.com www.andreabarbour.com