**Electronic Payment Information**

If you would like to pay by card, please complete this form. By completing and signing this form, you authorize Untangle Psychotherapy to keep this information on file and to charge your card in a recurring fashion for attended sessions, as well as for any sessions missed without prior notification, or notification within 24 hours of the appointment time. Should you receive a charge for a no show or late cancellation, you will be notified of the charge prior to billing. This authorization will remain in effect until cancelled in writing by you, or until treatment is terminated.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Client name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Billing Information**: | | | | | | | | | | | | | | | |
| Billing Address: | | |  | | | | | | | | | | | | |
| City: |  | | | | State: | | |  | | | | | Zip: | |  |
| Phone: | |  | | | | | | |  | |  | | | | |
| Credit Card Type: | | | | □ Visa | | | □ Discover | | | | | □ MasterCard | | | |
| Cardholder’s Name: | | | |  | | | | | | | | | | | |
| Credit Card #: | | |  | | | | | | | Expiry Date: | | | |  | |
| CCV Code: | | |  | | |  | | | |  | | | | | |

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**Signature**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
**Date**

*Service provided by Willow.*