ELECTRONIC PAYMENT AUTHORIZATION

Please complete the following information. Session fees for all clinical treatment with **Heidi Wilson, MBA, MA, LPC, CAC II** will be deducted from the account designated on this form. Forms of payment accepted: Visa, MasterCard, Discover. This form will be securely stored in your clinical file and may be updated upon request at any time.

***CLIENT INFORMATION*:**

Client Name:_____ **DOB:**_____

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*:**

Check One: Credit Card _____ Debit Card: _____

***ACCOUNT INFORMATION*:**

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

Card#:_____

Expiration Date:_____

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

_____ _____

Client Signature **Date**

Please return this form to your provider