



ELECTRONIC PAYMENT AUTHORIZATION

Please indicate the form of payment you wish to use for any services rendered through this practice. The following forms of payment are accepted: Visa, MasterCard, Discover, and Electronic Checks. This information will be securely stored in your clinical file and may be updated upon request at any time.

Please be aware that transactions will appear as “Therapy Partner” on your bank or credit card statement.

Contact Information:

Client Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Number: _____ Mobile Number: _____
Email: _____

Payment Type (check one): Credit/Debit Card: E-Check:

Credit/Debit Card Information:

Card Type (check one): Visa MasterCard Discover
Card Number: _____ Expiration Date: _____

-or-

Electronic Check Information:

Bank Name: _____
Routing Number: _____ Account Number: _____

Account Holder Information:

Please indicate the name and address associated with the credit card or bank account you wish to use.
Name: _____
Address: _____ City: _____ State: _____ Zip: _____

Signature of Client or Legal Guardian

Date

Please return this form to your therapist or fax to: 954.337.0454

LAURYN SALASSI GILLIAM, Ph.D. A.B.D., MFT