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Credit/Debit Card Payment Consent Form

Patient Full Name _____

Full Name on credit card (if different) _____

I authorize Jessica A. Golub Ph.D. and/or her billing associate(s) to charge my credit card for professional services for the balance of fees not paid by me or my insurance company.

Credit Card Number _____ - _____ - _____ - _____
(Unable to accept DEBIT cards at this time)

Exp. Date _____/_____

CVV Number _____ (3 digit # from back of card, or AMEX then 4 digit # on front right of card)

Card Holder's complete Billing Address for Monthly Card Statements

_____ _____ ____ _____
Street *City* *State* *Zip*

Card Holder E-mail Address (*to send receipt*) _____

A credit card receipt that does not contain the full credit card number may be e-mailed to you at the e- mail address above

Card Holder Signature _____ Date ____ /____ /____

Charges will appear on your card statement as Professional Services Rendered or similar iteration.