Washington Location:
603 4th Avenue, Suite 100
Kirkland, Washington 98033
206-785-2938

Texas Location:
12920 Dairy Ashford
Sugar Land, TX 77478
832-901-5038

info@wilsonpsychservices.com

CREDIT CARD AUTHORIZATION FORM

Please indicate the form of payment that you authorize for any services rendered through this practice. Information is securely stored in your clinical file and may be updated upon request at any time.

PATIENT / CLIENT INFORMATION:

NAME: _____

DATE OF BIRTH: _____ / _____ / _____
(Month) (Day) (Year)

ADDRESS: _____
(Street and Number)

_____ _____ _____
(City) (State) (Zip Code)

CELL PHONE: _____

HOME PHONE: _____

EMAIL: _____

CREDIT / DEBIT CARD INFORMATION:

Card Type: ☐ Visa ☐ Mastercard ☐ AMEX ☐ Other: _____

Card Number: _____ **Exp. Date:** _____ **CVV:**_____

CARD HOLDER INFORMATION:
Please indicate the name and complete address associated with this debit or credit card you wish to use for payment of services.

NAME: _____

ADDRESS:

_____

(Street and Number)

_____ _____ _____

(City) (State) (Zip Code)

_____ _____

SIGNATURE OF PATIENT / AUTHORIZED CARD HOLDER **DATE**