JAN WILLER, PH.D.
LICENSED CLINICAL PSYCHOLOGIST
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Credit/Debit Card Payment Consent Form

Patient Name _____
Print *Last* *First* *Middle Initial*

Name on Card if different _____

.

I authorize Jan Willer, Ph.D. and ProfessionalCharges.com to charge my card for professional services as follows:

Initial

_____ **All**: A convenience fee applies to all charges: $5 for amounts $1-99, and $10 for amounts $100 and up. This fee can be paid in cash or as part of the charge.

_____ **For self-pay:** Recurring charges until _____/_____/_____, Fees are as follows: First session: _____, 45 minute session: _____, 55 minute session: _____

_____ **When insurance is applied:** To charge my card for the balance of fees not paid by my insurance company within 90 days, as indicated above.

Type of Card: ☐ VISA ☐ MasterCard. ☐ Discover

Card Number _____ - _____ - _____ - _____

Exp. Date _____/_____

CVV Number _____ (3 digit # from back of card)

Card Holder's Billing Address for Monthly Card Statements

_____
Street *City* *State* *Zip*

Card Holder E-mail Address _____
A credit card receipt that does not contain the full credit card number will be e-mailed to you at the e-mail address above.

Card Holder Signature _____ Date ____ /____ /____

Charges will appear on your card statement as ProfessionalCharges.com or some abbreviation of it.