Authorization to Use Credit Card for Psychotherapy Services

I authorize Boston Evening Therapy Associates, LLC (BETA) to charge my credit card for the sole purpose of psychotherapy, consulting or counseling services rendered.

I authorize BETA to use my credit card for the following purposes:

Copayments for Insurance covered visits in the amount of: $_____

Private Payments for psychotherapy/consulting in the amount of: $_____

No Show/Cancel less than 24 hours in advance in the amount of: $_____

Patient Name: _____

Patient's Address: _____

Credit Card: (circle one) VISA , MASTERCARD, AMERICAN EXPRESS

Credit Cd#: _____

Exp. date: _____

3 digit code _____

I agree to pay the above total amount according to card issuer agreement.

Name (Please Print) _____

Signed: _____ Date:_____

Therapist Name (Please Print)_____

Signed: _____ Date:_____