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: $_______

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:_______________________