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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

\_\_\_\_\_ Recurring charges, date(s) of service \_\_\_\_ / \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ / \_\_\_\_,  
not to exceed \$\_\_\_\_\_, per visit.  
*(Fill this portion in if you are paying out-of-pocket)*

\_\_\_\_\_ to charge my card for the balance of fees not paid by my insurance company within 90  
days, as indicated above.  
*(Fill this portion in if you are paying with insurance)*

Type of Card:  VISA  MasterCard  Discover

Exp. Date \_\_\_\_/\_\_\_\_

Card Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

DVV Number \_\_\_\_\_ (3 digit # from back of card)

Card Holder's Billing Address for Monthly Card Statements

\_\_\_\_\_  
*Street City State Zip*

Card Holder Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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