Credit/Debit Card Payment Consent Form

Patient Name ____
Print Last First Middle Initial

Name on Card if different ____________________________________

I authorize Christy Lindquist, LCPC 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

3139 N Lincoln Ave
Suite 202
Chicago IL 60657
773-386-4414