

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