Family First
Psychological Services

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CREDIT CARD PAYMENT AUTHORIZATION

Name on Credit Card:

Billing Address (including zip code):

Phone Number:

Credit Card Number (Visa, Mastercard, or Discover only):

Expiration Date:

CV Number on the back of the card:

I authorize FamilyFirst Psychological Services, PC to charge my credit card for services provided. I understand that this charge will occur at the time of service.
I will receive a receipt that will allow me to submit to my insurance provider. I understand that my credit card information will be kept on file, but that the utmost caution will be taken in ensuring the confidentiality of this information.

Signature

Date