Associates in Psychotherapy
770 Lake Cook Road
Suite 220
Deerfield, Illinois 60015
(866) 220-8371

Credit Card Payment Consent Form

Patient Name _____
Print Last *First* *Middle Initial*

Name on Card if different _____

I authorize Associates in Psychotherapy, and Cayan.com, to charge my credit/debit card for professional services as follows:

Initial
_____ This visit only, for the amount of $ _____ .

_____ **To charge my card for the balance of fees not paid by my insurance company within 90 days, as indicated above.**

Type of Card: □ Visa, □ MasterCard, □ Discover, □ American Express Expiration Date _____

Credit Card Number _____ - _____ - _____ - _____ CVV Number _____

Card Holder's Billing Address for Credit Card Statements

_____
Street *City* *State* *Zip*

Card Holder Signature _____, Date ____ /_____ /____

If I have questions about these charges, I agree to contact **Associates in Psychotherapy (admin@chicagoclinicaltherapist.com).** I agree that I will not pursue a refund directly through my credit/debit card company, bank, or financial institution. If any of my actions yield a chargeback for any reason, I agree to pay any and all penalty fee(s) incurred by **Associates in Psychotherapy**.

Card Holder Signature _____

Date ____ /____ /____

We accept MasterCard, Visa, Discover, and American Express Credit and Debit Cards