

Credit Card Payment Consent Form



Patient Name _____
Print Last First Middle Initial

Name on Card if different _____

I authorize *David A. Yudell, Psy.D., and Card One International*, to charge my credit/debit card for professional services as follows:

Initial
_____ Recurring charges per visit in the amount of _____
_____ One time charge in the amount of _____

Type of Card: Visa MasterCard Discover American Express

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

3-digit number in reverse italics on the **back** of the credit card OR 4-digit on **front** of Amex cards

Expiration Date _____

Card Holder's Billing Address for Credit Card Statements

Street City State Zip

Card Holder Signature _____, Date ____ / ____ / ____