Sarit Lesser, Psy.D
Clinical Psychologist

154 Waterman st. Suite 10a
Providence, RI 02906

Credit Card Payment Consent Form

Payee Name ____

Name on card if different __________________________________

I authorize Sarit Lesser, PsyD to charge my account(s) for professional services and any associated fees provided to me or to: _______________, who is my ________________. *This authorization will also apply to any additional or subsequent account numbers provided to Sarit Lesser, PsyD for payment purposes.*

(Payee Initials)

______ Any fees (as accrued) related to appointments, phone consultations, services, late cancellations, or missed appointments, beginning __/__/__, and ending when treatment services are formally terminated.

______ A payment plan related to any of the above outlined activities, beginning on ____/____/_____, and ending when all fees have been paid in full **or** when treatment services are formally terminated, on the following basis: Amount $___________

______ A one-time charge, for the amount of $ ___________________

______ Other; ____

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Type of card: VISA ____ MASTERCARD _____ DISCOVER _____

Card Number: __________ - __________ - ___________ - _______________

Expiration Date: _____ / _____ **Security Number** (on back of card)**:** ________

Card Billing Address Zip Code:

____

Card holder's signature: _________________________ **Date:**____/____/____

This is a strictly confidential record. Redisclosure or transfer is expressly prohibited.