Gesell

Credit/Debit Card Payment Consent Form

Patient Name ____
Print Last First Middle Initial

Name on Card if different ____

I authorize Gesell Psychotherapy, LLC and ProfessionalCharges.com, to charge my credit/debit card for professional services as follows:

Initial

______ This visit only, for the amount of $ _____________ .

______ All visits in the next 12 months, beginning ______ /______ /______.

______ All visits beginning ______ /______ /______ until treatment ends.

______ Recurring charges, date(s) of service ______ /______ /______ to ______ /______ /______,

_____ monthly, _____ semimonthly, _____ weekly, _____ per visit.

______ 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

Card Number _________ - _________ - _________ - _________ CVV Number _______ Expiration Date _____________

A 3-digit number in reverse italics on the back of the credit card

Card Holder's Billing Address for Credit Card Statements

____
Street City State Zip

If I have questions about these charges, I agree to contact my provider and if necessary ProfessionalCharges.com via e-mail (info@professionalcharges.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 my provider.

Please send receipt by e-mail to: ____
Receipt will come from info@professionalcharges.com. Check junk mail folder.

Card Holder Signature ____, Date _______ /________ /_______

Charges will appear on your credit card statement as an abbreviation of ProfessionalCharges.com, usually PROFCHARGE.