

VISA/MASTERCARD PAYMENT FORM

Name on credit card:

Billing Address (including zip code):

Credit Card Number (Xerox copy of card will also be made):

Expiration Date: _____

CV Number on the back of the card: _____

I authorize the Center for Cognitive Therapy and Assessment (CCTA) 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 at the end of the month that will allow me to submit to my insurance provider. I also understand that I may continue to pay on a weekly basis by check if I prefer. I understand that the CCTA will keep my credit card information on file, but that the utmost caution will be taken in insuring the confidentiality of this information.

Printed Name

Signature

Date