PAYMENT CONSENT FORM

Name (as it appears on your card) _____

Name of client (if different) _____

I authorize Kristen Wynns, Ph.D, PLLC (dba Wynns Family Psychology) to charge my credit card for (choose one):

Initial /Check

_____ ☐ This visit only, for the amount of $_____

_____ ☐ All fees in the next 12 months, beginning date: _____

_____ ☐ All applicable provider fees. *We request a card on file for all Telehealth sessions.*

Type of Card: ☐ Visa ☐ M/C ☐ AMEX ☐ Discover ☐ HSA

Credit Card Number: _____ - _____ - _____ - _____

Expiration Date _____ CVV Number _____

Card Holder's Billing Address for Credit Card Statements:

Street					
City		State		Zip	
Email:					
Phone:					

I understand the WFP 48 hour cancellation policy and authorize applicable missed appointments fees to be charged to my credit card as required.

Card Holder Signature _____ Date _____

The date listed on your credit card statement may be different than the actual date of service.