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PH 720-261-4459

FORM OF PAYMENT

Please indicate the form of payment you wish to use for any services rendered through my practice. I accept the following forms of payment: Visa, MasterCard, Discover, Cash and Check. If you elect to use the credit card service, fees will be deducted from the designated account at the time services are rendered. This information will be securely stored in your clinical file and may be updated upon request at any time.

Payment Type:
Credit (Debit) Card: ☐ Check/Cash: ☐

Account Holder Information:
Please indicate the name and address associated with your credit card or debit card you wish to use.

Name: _____

Address: _____
Street City State Zip Code

Client date of birth: _____

Account Information:
Card Type (check one): ☐ Visa ☐ MasterCard ☐ Discover

Card Number: _____

Expiration Date: _____

CCV: _____

I certify the information provided above is accurate to the best of my knowledge. I also authorize any service fees to be deducted from the form of payment designated above. Should any of the information provided change, I agree to update this office as soon as possible.

_____ _____
Signature of Client or Legal Guardian Date