

CREDIT CARD CONSENT FORM

I authorize Joan L. Moreau, M.D. to keep my signature on file and charge to the following credit or debit card account in the amount shown below for psychiatric services. This payment agreement will be in effect until services have been completed or are ended by request of the client either verbally or in writing.

I assign my insurance benefits to the provider listed above. I understand this form is valid for 3 years unless I cancel the authorization through written notice to my provider.

Patient name(s): _____

CREDIT/DEBIT CARD INFORMATION:

Card Type: _____ Visa _____ MasterCard

Card Number: _____

Expiration Date: _____

Name on Card: _____

Billing Address: _____

Amount: _____

Cardholder's Signature: _____

Date: _____