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ELECTRONIC PAYMENT AUTHORIZATION

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time. I _____ give permission to have my card charged if I fail to make a payment or miss an appointment. You will be notified by Elana prior to any charge.

CLIENT INFORMATION:

Client Name: _____ DOB: _____

Responsible Billing Party Name (as shown on Credit Card/Account): _____

Billing Address (as registered with Credit Card Company):

Mobile Number: _____ Home Phone Number: _____

Email: _____

ACCOUNT INFORMATION:

Card Type (Visa, MasterCard, & Debit): _____

Card#: _____

Expiration Date: _____

Three Digit Card Code (Located on Back of Card): _____

Client Signature

Date

Please return this form to your provider