Credit/Debit Card Payment Consent Form

Patient Name _____
Print Last *First* *Middle Initial*

Name on Card if different _____

I authorize Clinical & Forensic Services and ProfessionalCharges.com to charge my card for professional services as follows:

_____ **to charge my card for the balance of fees not paid by my insurance company for each visit.**

Type of Card: ☐ VISA ☐ MasterCard ☐ Discover Exp. Date _____

Card Number _____ - _____ - _____ - _____ CVV Number _____

Card Holder's Billing Address for Monthly Card Statements

_____
Street *City* *State* *Zip*

If I have questions about these charges, I agree to contact **Clinical & Forensic Services** and if necessary ProfessionalCharges.com via email (info@professionalcharges.com). I agree that I will not pursue a refund directly through my credit/debit card company, bank, or financial institution. If any of my actions yield a chargeback for any reason, I agree to pay any and all penalty fee(s) incurred by **Clinical & Forensic Services.**

Card Holder Signature _____ Date:_____

Email Address_____

Charges may appear on your card statement as an abbreviation of **ProfessionalCharges.com** *usually* **ProfCharges.com**