LISA TALLANT, PSY.D. LLC

CREDIT CARD AUTHORIZATION FORM

Date: _____/_____/_____

Patient Name: _____

Type of Credit Card: ☐ Visa ☐ Master Card ☐ American Express

Charges will be applied based on frequency of psychotherapy sessions. After 6 months with no charges, the information will be destroyed and a new authorization form will be required in order to resume services. Credit card information will be given during an encrypted therapy session for your protection.

I agree to keep my credit card information on file with Lisa Tallant, PsyD, LLC

Cardholder Signature:_____

I hereby authorize charges to be made on my credit card for psychotherapy services with Dr. Lisa Tallant. I authorize Dr. Tallant to charge the credit card indicated in this form according to the terms outlined above in the amount agreed upon for services rendered. It is valid for repeated use following a psychotherapy session, at the end of the week. I certify I am an authorized user of this credit card and I will not dispute the payment with my credit card company if the transaction corresponds to the terms indicated in this form.