Client’s name: ____

Payment by Credit Card Option

Linda S. Budd, PhD, LP, LMFT, RPT-S has my permission to keep my signature on file and bill my credit card for payment of therapy service not paid at time of service.

I understand that this form is valid for 4 years and I have the option of discontinuing use of my credit card for payment of service by providing written notice.

I will also inform Dr. Budd if any of the information provided below changes.

Please bill my credit card: _____Visa _____MasterCard _____Discover

Name as it appears on the card: ____
(please print)

Card number: ____

CVV number (located on back of card): ________________________

Expiration date: ____

Signature: ____

Print Name: ____

Date: ____