

Patti Ashley, Ph.D., LPC

6800 North 79th Street ~ Suite H207, Niwot CO 80503

CREDIT CARD PAYMENT

DATE_____

PAYOR NAME_____

PATIENT NAME_____

ADDRESS AND **ZIP CODE**

ACCOUNT#_____CVV_____ EXP

DATE_____

This agreement provides Patti Ashley, Ph.D., LPC permission to charge my charge card as per my timeline, or in the event that I miss a scheduled appointment (I have provided less than 24 hours notice as we have agreed), I authorize payment of that on my credit/ debit card (Visa, MasterCard, Discover, and American Express) with \$5.00 service charge.

Printed Name_____

Signature_____

Date_____