Patti Ashley, Ph.D., LPC

www.pattiashley.com

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 if 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).

Printed Name_____
Signature_____
Date_____