THE CENTER FOR COGNITIVE THERAPY

VISA/MASTERCARD/AMERICAN EXPRESS PAYMENT FORM

Name (as it appears on card): _____

Billing Address (include zip code): _____

_____

Credit Card Number _____

Expiration Date: _____ CVV Number: _____

I authorize the Center for Cognitive Therapy and Assessment (CCTA) to charge my credit card for services provided. I understand that this charge will occur at the time of service. I will receive a receipt at the end of the month that will allow me to submit to my insurance provider. I also understand that I may continue to pay on a weekly basis by check if I prefer. I understand that the CCTA will keep my credit card information on file, but that the utmost caution will be taken in insuring the confidentiality of this information.

_____

Printed Name

_____ _____

Signature Date