**Psychotherapy Services of CT, L.L.C.**
Vernon, CT 06066
Phone: (860) 647-8995
Fax: (860) 647-6930

## Permission to Bill Credit Card on File

I, _____, give Psychotherapy Services of CT, L.L.C.

permission to bill my Credit Card # _____ CSC (_____)

expiration date _____ for a payment of $ _____

after each session.

**Please provide the following information in order to process your payment:**
**This information should reflect the information provided to the credit card company.*

**Billing Address:** _____

**City:** _____

**State:** _____

**Zip Code:** _____

**Phone Number:** _____

**E-mail:** _____
(For receipt of payment please fill in E-mail address.)

I understand that if I do not give 24 hours notice to cancel an appointment, I will be responsible for the $75.00 fee for the missed appointment and it can be billed to my credit card.

I understand Psychotherapy Services of CT, L.L.C. will keep this information on file for billing, Unless otherwise directed by me.

_____ _____
*Patient/Parent/Legal Guardian Signature* *Date*

_____ _____
*Witness Signature* *Date*

**Please Note:**
**1** As of August 10, 2010 for any refunds that are made, PayPal will be charging $0.30 to the patient's account.
**2** As of August 10, 2010 for all credit cards it will be **2.9%** plus **30** cents additional to the payment owed.
**3** As of Oct 25, 2010 there will be a **3.5%** charge for use of American Express in addition to the payment owed.

Revised: 7/12/2013