



I authorize The Bethesda Group Psychological Services, LLC to charge my credit card as noted below for all appointments, including cancellations without 48 hours notice.

Additionally, my card will be charged for additional time or services provided, following notification at the time of service. _____ (Please initial).

If the client is referred to another therapist within The Bethesda Group, or a date of service is being covered by a therapist within The Bethesda Group, I also authorize the card to be charged for those services. _____ (Please initial).

PLEASE PRINT INFORMATION CLEARLY (OR FORM WILL ACCEPT TYPED ENTRY):

DATE: _____

CLIENT'S NAME: _____ **DATE OF BIRTH:** _____

ADDRESS: _____

CITY, STATE, ZIP: _____

GUARANTOR'S NAME: _____ **RELATIONSHIP:** _____

HOME TEL. #: _____ **PREFERRED TEL. #:** _____

EMAIL ADDRESS FOR CREDIT CARD RECEIPT: _____

BILLING INFORMATION

TYPE OF CREDIT CARD: MasterCard _____ VISA _____ AmEx _____ Discover _____

Is this card a Debit card _____ Health Savings Account _____ Flexible Spending Account _____

NAME ON CARD: _____

CARDHOLDER'S ADDRESS: _____

CITY, STATE, ZIP: _____

Card number will usually be 16 digits for all cards except American Express which is usually 17 digits.

CREDIT CARD NUMBER: _____

EXPIRATION DATE: _____ **SECURITY CODE:** _____ (from back or front of card)

SIGNATURE: _____

Clinician: _____ Brian Corrado, PsyD _____ Patrick Mitchell, PsyD _____ Leila Bakry-Becker, PsyD
 _____ Charles Curtis II, PhD _____ Casey Perisin, PsyD _____ Wyneshia Hicks, LCSW-C
 _____ Lauren Barris, LCSW-C _____ Colby Whittington, LCSW _____ Anh Tu Duong-Guadio, LCPC