NeuroPsychological Institute, P.A.
Shawna Freshwater, Ph.D.
SpaciousTherapy.com
Electronic Payment Authorization Form

Please indicate the form of payment that you authorize for any services rendered through this practice. Information is securely stored in your clinical file and may be updated upon request at any time.

Patient/Client Information:

Name:_____
Date of Birth:_____
Address:_____
City:_____State_____Zip Code_____
Mobile number:_____
Home number:_____
Email:_____

Credit/Debit Card Information:
Card Type: _____Visa _____MasterCard _____AMEX
Card Number:_____
Expiration Date:_____/_____

Card Holder Information:
Please indicate the name and complete address associated with this debit or credit card you wish to use for payment of services.
Name:_____
Address:_____
City:_____State_____Zip Code_____

Signature of Patient/Authorized card holder:
_____
Date:_____

Please return this form. Thank you.