ARETE
psychological services

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DEDICATED TO EXCELLENCE IN THE INTELLECTUAL, EMOTIONAL AND BEHAVIORAL DEVELOPMENT OF YOUNG PEOPLE

Credit/Debit Card Payment Consent Form

Financially Responsible Party Name: _____
First *MI* *Last*

Name on Card if different _____

I authorize Dr. Scott Abbott and ProfessionalCharges.com to charge my card for professional services as follows:

Please Initial:

_____ Any agreed on session or service that is not paid for at the time service is rendered, unless other arrangements have been made for payment or I have a dispute concerning the service or payment for that service. No debits will be processed on my card until the dispute is resolved.

I have been informed that all information provided here will never be shared with any other parties, and that it will be stored and transmitted according to strict encryption protocols and meet all federal HIPAA requirements for privacy.

Type of Card: ☐ VISA ☐ MasterCard ☐ Discover Exp. Date _____

Card Number _____ - _____ - _____ - _____ CSC/Security Code# _____

Card Holder's Billing Address for Monthly Card Statements:

_____
Street City State Zip

Card Holder Signature _____ Date ____ /____ /____

*If I have questions about these charges, I agree to contact my provider (Dr. Abbott), and if necessary, ProfessionalCharges.com via email (info@professionalcharges.com). I agree that I will not pursue a refund directly through my credit/debit card company, bank, or financial institution. If any of my actions yield a chargeback for any reason, I agree to pay any and all penalty fee(s) incurred by my provider.