**Julie A. Pelletier, P.C.**
454 Rolling Ridge Drive, State College PA 16801
Ph. (814) 235-1100 x108 Fax (814) 235-1101

# CREDIT CARD AUTHORIZATION

Patient Name: _____ DOB: _____

I hereby authorize Julie A. Pelletier, P.C., to keep the following credit card information on file and process it for psychological services rendered in regards to the above-named patient.

I understand that my financial responsibility of charges known at that time will be processed after the end of each month. I will receive a statement summarizing all charges and payments processed that month.

Type of Credit/Debit Card: ☐ Visa ☐ MasterCard ☐ Discover

Card Number: _____

Expiration Date (mm/yy): _____ / _____ 3-Digit Security Code: _____

Cardholder's Name (print): _____

Billing Address: _____

_____ _____
Cardholder's Signature Date