

Myers Counseling Group Payment Consent Form

Patient Name: _____
 Print Last First Middle Initial

Name on Card if Different: _____

I authorize Myers Counseling Group, to charge my credit/debit card for professional services as follows:

Initial
_____ This visit only, for the amount of \$ _____ .

_____ Recurring charges(charges not covered by insurance including: copays, coinsurance, and/or deductibles), for date(s) of service ____ / ____ / ____ to ____ / ____ / ____ ,

Type of Card: G Visa, G MasterCard, G Discover.

Credit Card Number _____ - _____ - _____ - _____ ,

CVV Number _____ A 3-digit number in reverse italics on the **back** of the credit card

Expiration Date _____

Card Holder's Billing Address for Credit Card Statements

Street City State Zip

Card Holder Signature _____, Date ____ / ____ / ____

Myers Counseling Group
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