LOTUS
COUNSELING CENTER

ELECTRONIC PAYMENT AUTHORIZATION

Please indicate the form of payment you wish to use for any services rendered through this practice. This information will be securely stored in your clinical file and may be updated upon request at any time.

Client Information:

Client Name: _____ Date of Birth: _____

Address: _____ City_____ State: _____ Zip: _____

Home Number: _____ Mobile Number: _____

Email: _____

Credit/Debit Card Information:

Card Type (circle one): Visa MasterCard

Card Number: _____ Expiration Date: _____

Card Holder Information:

Please indicate the name and address associated with the credit or debit card you wish to use.

Name: _____

Address: _____ City_____ State: _____ Zip: _____

_____ _____

Signature of Client or Legal Guardian **Date**

Please return this form to your therapist.