SCW Psychological, Inc.

Dear Client,

We are deeply committed to the clinical care we provide and hope that each client experiences our therapeutic practice and office procedures as seamless, beneficial, and fulfilling. As such, you will not be required to take time to submit payment during your session. This allows us to focus on quality clinical care while preserving the clinical time you deserve.

***Forms of Payment*:**

Your designated payment type will be used to process payment for all clinical services rendered. The following forms of payment are accepted through the practice: **Visa, MasterCard, and Discover (Credit or Debit)**

Cash & Personal Checks are acceptable as well, but are preferred on an as needed basis.

***Monthly Statements*:**

At the end of each month, you will automatically receive an insurance-ready statement via email. If you seek reimbursement from a healthcare plan privately, you may use this statement to do so.

Your questions and concerns are welcome in your upcoming sessions.

Sincerely,

Suzanne Carroll Woodard, Ph.D.

ELECTRONIC PAYMENT AUTHORIZATION

Please indicate the card you wish to use for all services rendered through this practice. Charges for services rendered will be deducted from the card designated below at the time services are rendered. We accept: Visa, MC and Discover.

Client Information:

Client Name: ____ Date of Birth: ________________________

Address: _________________________ City______________________ State: _________ Zip: __________

Home Number: __________________ Mobile Number: ________________ SSN:______________________

Email: ____

Billing Information:

Please indicate the information associated with the debit card you wish to use. ☐ I prefer to use a credit card.

Name: ____

Address: _________________________ City______________________ State: _________ Zip: _________

Email: ____

I authorize all service fees to be deducted from the card ending in _____________ (last four digits of the card)

Please enter the CVV code ___________ (last three digits on back of card)

I authorize the use of this card for all services and fees at the time they are rendered for the following parties:

Full Name(s) ____

I understand that this form authorizes my provider to charge this card for varying session types, across multiple dates of service. *By authorizing use of this card, and signing this electronic payment authorization form, I certify that I am the cardholder and my signature below authorizes each individual charge for all dates of service.

____ _________________________

Cardholder Signature **Date**

Payments are processed by Therapy Partner.
Therapy Partner is a registered ISO/MSP of Fifth Third Bank, Cincinnati, OH and HSBC Bank USA National Association, Buffalo, NY.

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Debit Card Information: ☐ I prefer to use a credit card.

Please provide your payment information below. The card information you provide on this form will be destroyed once your information has been securely encrypted and stored.

Card (circle one): Visa MasterCard Discover

Card Number: ____ Expiration Date: __________________