SWANSON, CONTI & ASSOCIATES
A PSYCHOLOGICAL CORPORATION

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Permission to Use Credit Card to Bill for Services

Dear Client,

We are excited to inform you that, due to several requests from our clientele, we have decided to begin accepting major credit cards. If you would like to take advantage of this billing method, please complete the form below and return it to your therapist.

Type of Card: ☐ Visa ☐ Mastercard

☐ American Express ☐ Discover

Name on Credit Card: ________________________________

Credit Card Number: ________________________________

Expiration Date: _____ / _____ **Security Code:** _________

By signing below, I give Swanson, Conti & Associates ("SCA") permission to bill my credit card for any and all services ("Services") my family or I have received after such Services have been provided. I acknowledge that I have been given a Fee for Service Schedule ("FFS") before the beginning of treatment and I understand that any and all charges will be billed in accordance with the FFS. Furthermore, understand that a fee of $10.00 will be applied for all credit card transactions completed.

____ ____________________

Signature of Cardholder Date

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Email Address