



Swanson, Conti & Associates

A Psychological Corporation

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Permission to Use Credit Card to Bill for Services

Please complete this form to have your credit card added to your file. Your credit card will only be billed/processed for services after such services have been rendered (*Unless otherwise agreed to in writing*).

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