Bank Card Payment Authorization

☐ ☐ ☐ ☐

Client Name: _____

Amount to be charged:_____

Card Account Number:_____

Cardholder Name:_____

Expiration Date:_____ CVV: _____

Cardholder Signature:_____

I understand that my credit card information will only be used for co-pays and any unpaid balance which I owe and that this information will be destroyed when I stop receiving services at Central Iowa Psychological Services.

Cardholder Signature:_____ Date:_____