



Credit Card Payment Form

Payment Information: Please Print in Black Ink

I authorize Lewisville Family Counseling, PLLC (LFC, PLLC) to charge my credit card for reoccurring payments/co-payments for counseling services, as well as for Late Cancellation fees as described in the Professional Disclosure Statement.

Type of Card: Visa MasterCard Discover American Express
Is this a FLEX SPENDING CARD or HEALTH SAVINGS ACCOUNT Card? : Yes No

Credit Card # _____ Exp Date _____

CVV# _____ (3-digit security code)

Cardholder's Name (Exactly as it appears on card): _____

Billing Address: _____ Apt or Suite No _____

City: _____ State: _____ Zip: _____

Phone: _____

Signature of Cardholder: _____

If the above listed card is attached to either a Flex Spending Account or Health Spending Account, please provide information for a secondary credit card. This secondary account will be charged if the payment is not approved by the FSA/HSA card, and it will also be used for any Late Cancellation fees as set forth in your counselor's Personal Disclosure Statement.

Type of Card: Visa MasterCard Discover American Express

Secondary Credit Card # _____ Exp Date _____

CVV# _____ (3-digit security code)

Cardholder's Name (Exactly as it appears on card): _____

Billing Address: _____ Apt or Suite No _____

City: _____ State: _____ Zip: _____

Phone: _____

Signature of Cardholder: _____

Permission to use email address for receipts: Yes No

Preferred Email: _____

I authorize Lewisville Family Counseling, PLLC to draft my credit card for counseling services including payments/copayments and/or Late Cancellation fees. I also authorize the provider to release any information acquired during treatment necessary to process claims. I also authorize Lewisville Family Counseling, PLLC to send email receipts of payments made either in person or electronically.

Signature: _____ Date: _____