**LOGAN PERSONS JONES, PSY.D.**

Licensed Clinical Psychologist

34 W 22nd Street, 2B, New York, NY 10001

646.798.8354

**CREDIT CARD AUTHORIZATION FORM**

**Personal Information**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Credit Card Information**

Credit Card Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CVV Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize Logan Persons Jones, Psy.D. and Persons Psychology, PLLC to charge this credit card for invoices billed to me from this date forward. I agree that my per session fee will be $\_\_\_\_\_\_\_\_\_\_. I understand and acknowledge that I may be responsible for the fee in the event that I do not cancel with at least 24 hours notice. I understand that payment for each session will be taken within 24 hours of the visit. This agreement will expire at the termination of our working relationship.

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Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name