



Psychological Health, Wellness, & Development, Inc.

CREDIT CARD ON FILE AUTHORIZATION FORM

PHWD Inc. is offering a secure and convenient method of credit card payment through Stripe and Simple Practice. Your credit card information is kept confidential and secure in your file in a locked cabinet. In the Consent for Services reviewed and signed by you, the conditions under which your credit card is charged are listed. The highlights are listed below:

1. You authorize PHWD to charge your session fee with your credit card at the time of the session.
2. You agree to pay at the time of the session by cash or check at a discounted rate. PHWD gives you a 14 day grace period to make your payment. If your payment is past due by 14 days, you will be charged a \$35.00 late fee. PHWD will charge your credit card on file for the non-discounted session rate and the late fee to secure payment for the service provided.

I, _____, authorize PHWD Inc. to capture my credit card information and securely store my credit card on file.

I understand this form is valid until I give a 30-day written notice to cancel the authorization to PHWD Inc. Written notice must be submitted to PHWD Inc. at 12401 Wilshire Blvd., Suite 300, Los Angeles, CA 90025.

I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Client Name: _____

Parent/Guardian Name: _____

Card Holder's Name (as shown on card): _____

Type of credit card (please circle):

Visa Master Card Discover American Express

Card Number: _____

Expiration date (mm/yy): _____ CVV: _____ Billing Zip: _____

Signature

Date