THE PSYCHOLOGY CENTER
7617 Mineral Point Rd, Suite 300
Madison, WI 53717-1623
Phone: (608) 833.9290 Fax: (608) 833.9691

AUTOMATIC PAYMENT PLAN

I authorize **The Psychology Center** to automatically charge my credit card *(Visa, Mastercard, Discover, American Express)* listed below for items listed on the monthly statement for:

_____ _____
Client Account Number Client Name

This authorization is to remain in effect until I cancel in writing.

The **Payment Plan** I prefer to be on is:

☐ Pay the entire amount after each visit.
☐ Pay the entire amount at the end of each month
☐ Monthly Payment Plan: a monthly payment of $ _____ per month to be processed on the _____ day of each month.
☐ A one-time payment of $ _____

CARD TYPE	CARD NUMBER	EXPIRATION DATE	EFFECTIVE DATE
Mastercard			
Visa			
Discover			
Am. Express			

Name as it appears on the card (please print) _____
Authorized Signature _____ Date _____
Home Telephone # _____ Work Telephone # _____
Home Address _____

☐ **I authorize a minimum charge of $ _____ a maximum charge of _____** ☐ **Not applicable**
☐ **No minimum or maximum limit.**

For Office Use Only

_____ _____ _____
_____ _____ _____
_____ _____ _____