Kortanek Psychological Services, Inc.

24800 Chagrin Blvd. Suite 103
Beachwood, OH 44122
Phone: (216) 245-6231
Fax: (216) 245-6351
Email: info@kortanekpsych.com

Credit/Debit Card Payment Consent

Client name _____

Name on card if different than client _____

Card Type _____

Credit card number _____ CVC Code _____

Expiration Date _____ Billing Card Zip Code _____

I authorize Kortanek Psychological Services, Inc. to charge my credit/debit/health account card for professional services rendered. If I do not cancel my session before 24 hours, I acknowledge that Kortanek Psychological Services, Inc. may charge my card a late cancel/no show fee. I understand and agree that I may be billed for the full session charge. I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect, fraudulent, or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing and initialing this form that if no payment has been made by me, my balance can go to collections if another alternative payment is not made within ninety days.

Client Signature _____

Card holder Signature (If different than client) _____

Date _____