

Payment is due at the time services are rendered

In order to avoid costly collection procedures, we request that all clients provide a back-up credit card number and authorization for use for late payments.

By signing this waiver, I give authorization for charges to be made to my credit card by the Center for Child & Family Development following all telehealth sessions and in the event that I fail to pay for any services within 30 days of the date the services were rendered.

Card Type:    VISA            MasterCard    AMEX (Please circle one)

Card Number: \_\_\_\_\_

Expiration date: \_\_\_\_\_

V-Code:        \_\_\_\_\_

Address where the bill for this credit card is received:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

\_\_\_\_\_  
Person whose name appears on the credit card

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature