*Capital Psychological Services, LLC*

*5530 Wisconsin Avenue, Suite 1528*

*Chevy Chase, MD 20815*

*301-501-0130*

**CREDIT CARD FORM**

**\*\*\*NO NEED TO FILL OUT IF YOU PLAN ON PAYING BY CHECK OR CASH\*\*\***

Name on Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address (including zip):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number on the card:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Code on Back of card:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Card (circle) : **Mastercard or VISA (we do not take American Express or Discover)**

\*Copy of Card needs to be shown to practitioner to enter it into billing system. This billing system is a secure system that is also HIPAA compliant and as a practitioner I do not have access to the full number once it is entered.\*

I authorize Capital Psychological Services (CPS), LLC to charge my credit card for services provided. I understand that this charge will occur at the time of service. I also understand that the card may automatically be charged for missed appointments or cancelation with less than 48 hours. I will receive a receipt that will allow me to submit to my insurance provider. I also understand that I may continue to pay on a weekly basis by check if I prefer. I understand that the CPS LLC billing system will keep my credit card information on file.

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Signature Date