Manhattan Psychology Group, PC
107 West 82nd St Suite P101
New York NY 10024
646-389-4112

Credit/Debit Card Payment Consent

Email:

Patient First and Last Name:

Cardholder's relationship to patient (if different than patient):

Card Type: ☐ Visa ☐ Mastercard ☐ American Express ☐ Discover ☐ Other

Card Number:

Expiration Date:

Security Number (CVV Code):

Cardholder's Billing Address:

I authorize Manhattan Psychology Group (MPG) to charge my credit/debit/health account card for professional services rendered.

☐ Yes ☐ No

If I do not show for my appointment or cancel within 24 hours, I recognize that MPG will bill the full session rate as a no show or late cancellation.

☐ Yes ☐ No

I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or 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.

☐ Yes ☐ No

I also understand by signing and initialing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

☐ Yes ☐ No

Patient Initials:

Cardholder Initials (If different than patient):

Patient/Parent/Legal Guardian Name:

Electronic Signature:

Date: