MPG Credit/Debit Card Payment Consent

Patient First and Last Name: _____
Date of Birth: _____
Cardholder's First and Last Name: _____

Card Type:

☐ Visa ☐ Mastercard ☐ American Express ☐ Discover ☐ Other: _____

Card Number: _____
Expiration Date (MM/YY): _____
Security Code (CVV): _____
Cardholder's Billing Zip Code: _____

By signing below, I authorize Manhattan Psychology Group (MPG) to charge my credit, debit, or HSA/FSA card for professional services rendered.

Please review and acknowledge the following policies by checking each item and initialing and dating at the bottom.

1. **I authorize MPG to charge my card for services rendered.**

2. **I understand that if I do not attend my appointment or cancel within 24 hours, MPG will charge the full session rate as a late cancellation or no-show fee.**

3. **I verify that the above credit card information is accurate to the best of my knowledge. I understand I am responsible for the full balance if the payment is declined, inaccurate, or flagged as fraudulent.**

4. **I understand that if no payment has been made and no alternate arrangements are in place within 30 days, my balance may be sent to collections.**

Acknowledgment

Cardholder Name: _____
Date: _____