William K. Galer, LMFT
Psychotherapy Services

Electronic Payment Authorization

Please indicate the form of payment you wish to use for any services rendered through this practice. The following forms of payment are accepted in order of clinician preference: Cash, Check, Visa, MasterCard, Discover and American Express. This information will be securely stored in your clinical file and may be updated upon request at any time. Per office policy and to protect the clinician in the event of a No Call No Show, or Late Cancellation all clients must have a credit card on file.

Contact Information:

Client Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Email: _____

Preferred Payment Type (check one):

Cash _____ Check _____ Credit/Debit Card: _____

Credit/Debit Card Information:

Card Type (circle one): Visa MasterCard AMEX Discover

Card Number: _____

CVV# _____ Expiration Date: _____

Account Holder Information (if different from above):

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

_____ _____

Signature of Client or Legal Guardian **Date**