

**Psychology Forward
Joseph Graybill, Ph.D.
Psychologyforward.com
Electronic Payment Authorization**

Please indicate the form of payment that you authorize for any services rendered through Psychology Forward. Information is securely stored in your clinical file and may be updated upon request at any time. Please be advised a 3.6% fee for payment by credit card will be added, using Square to process your payment.

Client Information

Name: _____ **Date of Birth** _____
Address: _____
City: _____ **State:** _____
Country: _____ **ZipCode:** _____
Mobile Number: _____
Email: _____

Credit/Debit Card Information:

Card Type: ___ Visa ___ MasterCard _____ AMEX Card
Number: _____ **Expiration Date:** ___/___

Card Holder Information:

Please indicate the name and complete address associated with this debit or credit card you wish to use for payment of services.

Name: _____
Address: _____
City: _____ **State** _____ **Zip Code** _____ **Country:** _____

Signature of Patient/Authorized card holder:

_____ **Date:** _____

Please return this form. Thank you.