PINNACLE
Mental Wellness Group
A Counseling Community

130 E. Leland, Suite C
Pittsburg, CA 94565
Main Line: 925.384.3997
Fax: 925.252.1618
www.PinnacleMentalWellness.com

Credit Card Payment Consent Form

Patient Name_____
Print Last *First* *Middle Initial*

Name of Card holder if different_____

Email address for receipt to be sent: _____

I authorize Pinnacle Mental Wellness Group, and Intuit to charge my credit/debit card for professional services as follows:

- ❑ Psychotherapy
- ❑ Neurofeedback
- ❑ Other:_____

Type of card: ❑Visa ❑MasterCard ❑Discover

Credit Card Number _____-_____-_____-_____,

CVV Number _____
A 3-digit number in the reverse italics on the back of the credit card

Expiration Date _____

Card Holder's Billing Address for Credit Card Statements

_____
Street *City* *State* *Zip*

If I have questions about these charges, I agree to contact my provider listed above. I agree that I will not pursue a refund directly through my credit/debit card company, bank, or financial institution. If any of my actions yield a chargeback for any reason, I agree to pay any and all fee(s) incurred by my provider.

Card Holder Signature _____ Date ____ /____ /____