

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 ____ / ____ / ____