



Credit Card Payments

Please provide the following information.

Name as it appears on the credit card:

Email you would like receipt sent to:

Credit Card Numbers:

Type of Credit Card:

Mastercard Visa Discover

Expiration Date:

Month /Year

Security Code: (this appears on the back side of card, right of the signature)

Zip Code: (for billing address)

Please review the information provided above and by signing this form you approve Murphy Counseling and Therapy Services to charge this card for the following transactions:

Copays Patient Responsible Payments Late/no show fees

Misc _____.

One-time charge Amount: _____

This form will be good for one year from date of signature or only good for one charge on One-time charge.

Signature: _____ Date: _____