Transcendent Truth Incorporated

Electronic Payment Authorization

Please complete the following information, which will be securely stored in your clinical file and may be updated upon request at any time.

I,_____ give permission to have my credit/debit card charged for an appointment, missed appointment, or any unpaid balances. I understand I will be notified prior to any charge.

Client Information

Name: _____

Name as shown on the Credit Card: _____

Billing Address: _____

City/State: _____ Zip Code: _____

Phone Number: _____

Email: _____

Type of Credit Card

Visa___ MasterCard____

American Express____ Discover____ Debit____

Card Number: _____

Expiration Date_____

Security Code (CCV): _____

_____ Signature

Transcendent Truth Incorporated Credit Card Payment Form V1.0

Date Completed _____