

**PAYMENT AUTHORIZATION FORM**  
**For: Assessments, One-time payments, and Consultations**

Date: \_\_\_\_\_ Client Name: \_\_\_\_\_ Clinician: \_\_\_\_\_

**Description of Charge**

<input type="checkbox"/> ___(initial) First Installment Assessment	Amount: \$ _____
<input type="checkbox"/> ___(initial) Second Installment Assessment	Amount: \$ _____
<input type="checkbox"/> ___(initial) Consultation: # of hours _____	Amount: \$ _____
<input type="checkbox"/> ___(initial) Other: _____	Amount: \$ _____

**CREDIT CARD INFORMATION**

Client's Name: \_\_\_\_\_  
First Last

Client's Email: \_\_\_\_\_

Cardholder's Full Name: \_\_\_\_\_  
(as appears on credit card) First Last

Cardholder's Email (if different than Client's email) \_\_\_\_\_

Address of Cardholder: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

CARDHOLDER'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

*My signature indicates that I agree to the one-time charge in the amount indicated above by my initials.*

**-OR-**

CARDHOLDER'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

*My signature indicates that I authorize The Wake Kendall Group PLLC to charge my credit card account for the services rendered. I understand that this authorization is valid for the entire time the client receives services from The Wake Kendall Group PLLC and until the balance is paid in full unless I cancel the authorization through written notice. I also agree to contact The Wake Kendall Group PLLC if there are any changes to my credit card account information.*

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**Type of Credit Card:** \_\_\_\_\_ **Credit Card #:** \_\_\_\_\_

**Expiration Date:** \_\_\_\_\_ **3 or 4 digit Security Code:** \_\_\_\_\_