William E. Spaine, Psy.D.
Kathleen Kling, Ph.D.
Karen Scott, LCSW

Authorization to Bill Credit Card

Date: ____________

Card Information:

Name on Card: ______________________________ Card Type: ☐ Visa ☐ MasterCard

Card Number: ______________________________ CSV: ______________________
(The 3-digit code on the back of the card)

Expiration Date: ______________________

Billing Address:

Street: ____

City: ____________________ State: ______ Zip: __________

Telephone: ____________________

I hereby authorize Fayetteville Psychotherapy Associates, PLC to charge the card listed above for recurring charges in my/ the Patient's ongoing treatment. I understand that it is my responsibility to notify Fayetteville Psychotherapy Associates, PLC, if I wish to cancel this agreement.

Cardholder Signature: ______________________________

Patient Printed Name: ______________________________

225 North East Avenue Fayetteville, AR 72701
Phone: 479-442-8900 Facsimile: 479-442-8901
www.faypsych.com

Fayetteville Psychotherapy Associates is not a partnership or joint venture. It is an unincorporated association of practitioners, each of whom is an independent contractor.