Sharon Burge RN, MA, LCPC, RDDP

33 E. Colorado Avenue, Frankfort Illinois 60423 Office: (815) 469-6480 Fax: (815) 469-6481

Optional Credit / Debit Card Payment Consent Form

As a courtesy we can keep your credit card information on file for outstanding charges. You may revoke this optional agreement at any time.

Patient Name _____ _____

Last *First*

Name on card if different _____

I authorize Sharon Burge to charge my card for professional services as follows:

Initial

_____ To charge my card for the balance of fees including deductibles, copayments or co insurance amounts.

Not to exceed $ _____ per visit.

Type of card: ☐ Visa ☐ Master card ☐ Discover ☐ American Express

Card Number: _____-_____-_____-_____

Expiration Date: _____/_____

CVV Number: _____ (3 digit # on back of card or 4 digit # on front of card for American Express)

Zip Code of Billing Address _____

A receipt for payment can be issued to you via email or text to your cell phone

Card Holder Email Address: _____

Card Holder Cell Phone Number: (_____) _____

Card Holder Signature: _____ Date: _____