Credit Card Authorization

☐ Visa ☐ Mastercard ☐ American Exp. ☐ Discover

Client Name:_____ Client DOB: _____

Name on Card: _____

Account Number:_____

Expiration Date:_____ Security Code: _____

Billing Street Address:_____

City, State, Zip: _____

Email for Receipt:_____

Relationship to Client:_____Phone Number:_____

My signature below authorizes Albert Knapp & Associates A Psychological Corporation (AKA) to charge my credit card in accordance to our agreed upon fees as outlined in the Client Service Agreement document for all services provided, including services billed to and denied by the insurance company or other funding source. Additionally, my signature below authorizes AKA to charge my credit card for all late or same day cancelations, and no-show appointments.

Authorized User (Print): _____

Authorized User (Signature): _____

Date: _____