Credit Card Agreement

Please fill out this agreement if you would like Dana A. Max, Psy.D. to use your credit card to remit payment.

- ❑ Please use my credit card to pay any balance in full at the end of each month (statements available upon request).
  - o Do not include No Show/Late Cancellation Fees on this balance (only necessary for Medical Debit cards or Flex Plans).

- ❑ Please use my credit card for a one time payment of: _____.

- ❑ Please use my credit card for monthly payments of _____to be made on the first of every month until my balance is paid in full.

_____ _____
Signature Date

Type of Card:

- ❑ Visa
- ❑ Master Card
- ❑ American Express

Card Number: _____

Expiration Date: _____/_____ (mm/yyyy)

Security number on Card: _____

Name on Card: _____

Address of Billing Address for Card:

_____
(House Number and Street Name)

_____ _____
(City) (Zip Code)

Phone Number: _____