John R. Lucy, Ph.D.
Decatur Psychology, LLC
125 E. Trinity Place, Suite 202
Decatur, GA 30030
(404) 513-6077

Credit/Debit Card Payment Consent Form *

I authorize **Decatur Psychology, LLC** to charge my card for professional services as follows (please initial):

_____ All visits and late cancellation/no show fees ($50 if not done within 24 hours of appointment), not to exceed $150 total charge per visit unless I request to pay otherwise with cash, check, or another credit card.

_____ For the balance of fees not paid by my insurance company within 90 days, not to exceed $150 total charge per visit.

**** I understand that I have a right to revoke this authorization at any time. I understand that if I want to revoke this authorization, I must do so by writing or emailing John Lucy. I understand that any revocation will not apply to any charges run prior to this cancellation date.***

Client Name _____
Print Last First Middle Initial

Name on Card if different _____

Type of Card: ☐ VISA ☐ MasterCard ☐ Discover ☐ AmEx **Exp. Date _____**

Card Number _____ - _____ - _____ - _____ **CVV Number _____**

Card Holder's Billing Address for Monthly Card Statements:

_____
Street City State Zip

_____ _____
Email address (only if you want copies of receipts) Phone Number

Card Holder Signature _____ Date ____ /____ /____

NOTE: Charges will appear on your card statement as **Decatur Psychology, LLC**