Therapeutic Time, Inc.

Credit Card Agreement

Sarah Barajas, MA, Psychological Associate PSB 94027905
Liliana Chavez Weichold, MA, Psychological Associate PSB 94027514
Dr. Trisha Rich-Thurm, PsyD Licensed as a Clinical Psychologist PSY 24976,
Marriage & Family Therapist MFC 42603, & National Certified Counselor NCC 264935
therapeutictimeinc@therapyemail.com **Phone (661) 714-2028 Address 44349 Lowtree Ave Suite 101 Lancaster CA 93534**

Client Name: ____ DOB: ________________

By signing this document, I hereby authorize (check one):

☐ **Trisha Rich-Thurm, Clinical Psychologist PSY 24976**
☐ **Liliana Weichold, MA, Psychological Associate PA# PBS94027514**
☐ **Sarah Barajas, MA, Psychological Associate PA# PSB 94027905**

We currently accept Debit or Credit cards with the Visa & Mastercard logo.
With this consent, your credit card will be kept securely on file and fees will be applied under the following conditions. By signing this document, you agree to the following:

- I authorize Therapeutic Time Inc. to apply fees or co-payment at the time of services rendered.
- I authorize Therapeutic Time Inc. to apply for a fee to be designated by the therapist (not to exceed the full fee amount) for any services missed and not canceled within 24 hours of its scheduled time.
- I authorize Therapeutic Time Inc. to apply for any fees that are unpaid after 45 days. I understand that I may revoke this agreement in writing at any time.
- It is my responsibility to provide a valid card to be on file. (In the event a card expires or has been reissued it is your duty to let the therapist know.)
- **I authorize Therapeutic Time Inc. to apply a 3.25% credit card charge when using the credit card for payment.**
- For all billing needs please contact us at therapeutictimeincbilling@therayemail.com

Please fill in all text boxes below:

The card is to be used for the following client(s) (use full legal names please):

_________________________ _________________________ _________________________

Names (as appears on card) ____________________________________ Card type ___________

Card # _______________________________________ Expiration date _____________________

Security code (three digits on the back of the card) __________ Zip Code ________________

Your signature below indicates that you have read the information in this document and agree to its terms.

___________________________ _________ In the case of treating a minor: **Sign Below**:

Signature of Client Date

____________________________ ________ ____________________________ ________

Signature of Parent/Guardian Date Signature of Parent/Guardian Date