



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 661-714-2082 / 1043 West Ave, M4 Suite B Palmdale CA 93551 / Fax 661-466-2029

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 therapeutictimeinc@therapyemail.com / 661-714-2082

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.

Signature of Client

Date

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

Signature of Parent/Guardian

Date

Signature of Parent/Guardian

Date