



Krysta J. Oehm, M.A., PLMHP / 402-631-1985
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CREDIT/DEBIT CARD AUTHORIZATION FORM

CARDHOLDER NAME: _____

ZIP CODE OF CARD BILLING ADDRESS _____

CREDIT/DEBIT CARD TYPE (CIRCLE):

VISA MASTERCARD DISCOVER AMERICAN EXPRESS

CREDIT/DEBITCARD NUMBER: _____

EXPIRATION DATE: MONTH _____ YEAR _____

CVV SECURITY CODE: _____

INSURANCE COPAYMENT: \$ _____ (recurring per session)

PRIVATE PAY FEE: \$ _____ (recurring per session)

The signature provided below authorizes Mind Matters LLC to charge the dollar amount listed above to the credit/debit card provided. I understand this authorization will remain in effect, and this card's information on file, until therapy services are discontinued. I understand that the credit/debit card provided will be charged automatically for any past due balances on the last day of each month and an invoice will be provided to the client reflecting this transaction. I agree that I will pay for this purchase in accordance with the issuing bank cardholder agreement.

CARDHOLDER SIGNATURE

NAME (PLEASE PRINT): _____

SIGN: _____

DATE: _____

*All information will remain confidential