ATLAS
PSYCHIATRY

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Atlas Psychiatry New Client Intake

Name: _____
Last First Middle Initial

Address: _____
Street City State Zip

Phone: _____ **Email:** _____

Date of Birth: ____ /____ /_____

Credit/Debit Card Payment Consent Form

I authorize **Atlas Psychiatry, PLLC** to charge my credit/debit card for professional services as listed in the service agreement including appointment fees, late cancellation fees, bounced check fees, administrative fees, court appointment fees, and other court related fees such as phone calls, emails, or release of documents.

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 Matthew D. Huether, ARNP, PMHNP-BC (office@atlaspsychiatrycr.com). I understand that any revocation will not apply to any charges run prior to this cancellation date.

Name on Card: _____

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

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

Billing Address (if different than above):

_____
Street City State Zip

Do you want an emailed copy of receipts? Y / N

Card Holder Signature _____

Date ____ /____ /_____