CAROL UMMEL LINDQUIST, PH.D., FACLINP
CLINICAL PSYCHOLOGIST

THE PSYCHOLOGY CENTER
380 GLENNEYRE SUITE D
LAGUNA BEACH, CA 92651

# Pre-Authorized Credit Card Form

Client Name _____

I authorize Carol Ummel Lindquist, Ph.D. to keep my signature on file and to charge my credit card from time to time for my treatments.

I understand that payment is due at the time of treatment and that my credit card may be charged at any time after my appointments.

Credit Card Information
☐ VISA ☐ MasterCard ☐ American Express ☐ Discover

Name on Credit Card _____

Credit Card #: ____ ____ ____ ____--____ ____ ____ ____--____ ____ ____ ____--____ ____ ____ ____

Expiration Date (MM/YY) _____/_____ Security Code (CVV)_____

Billing Address_____

City _____ State_____ Billing Zip_____

Telephone _____ Email address _____

**X**_____
**Cardholder Signature** **Date**