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PAYMENT INFORMATION

Payee Name: _____ D.O.B: ____/____/____
M/ D/ Y

Patient Name _____ D.O.B: ____/____/____
(if different from above) M/ D/ Y

Will you be paying for sessions by Credit Card Debit Cheque Cash

Credit Card Information

Master Card

Visa

Name on Card _____

Card Number: _____

Expiry Date: _____ (M/Y)

Card Security Code (CSC): _____

Payment is processed automatically at each scheduled appointment unless otherwise arranged. If you are paying by credit card your account will be charged via Intuit Merchant Services.

I have read, asked questions that I needed to, and I understand Dr. Reist's informed consent document. I agree with fee policies including cancelled and missed appointments.

Signature _____ Date: _____