LEIGH ANNE B. TERREBONNE, Ph.D.
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CREDIT CARD CONSENT FORM

I hereby authorize Leigh Anne B. Terrebonne, Ph.D., LLC to charge my Visa/ MasterCard//Discover/Diner's Card account as indicated below:

An authorized charge will *only* be made under the following circumstances:

- Patient Approval
- Missed Appointments
- Cancellations made less than 24 hours from the time of a scheduled appointment
- Past Due Balances

A processing fee of $2.50 will be added to each charge.

Please check one:
□ Visa
□ MasterCard
□ Discover

Patient Name: _____

Cardholder Name: _____

Cardholder Billing Address:

Street _____

City _____ **State** _____ **Zipcode** _____

Account Number: _____

Card Verification # _____

Exp. Date: _____

Cardholder Signature _____ **Date** _____

This authorization is valid for one year unless you cancel the authorization through written notice to Leigh Anne B. Terrebonne, Ph.D.