ANDREA BERNARD, PH.D.
Licensed Psychologist
PSY 13143
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Tel/Text.: 760.815.8682

PAYMENT CONSENT

I, _____ (PRINT NAME), hereby grant my consent that Andrea Bernard, Ph.D., use my credit/debit card on file to charge for services related to my/my minor child's psychological treatment with her (including deductible, co-payments, co-shares, and missed or late-cancelled appointments), as agreed in the Office Policies and Information agreement that I signed at the onset of treatment with Dr. Bernard.

Please enter your payment information below:
(This information will be kept safe and confidential)

_____
Credit card number

_____
Name on card

_____ _____
Exp. date CVV #

_____ _____
Zip code E-mail address

_____ _____
Signature Date