Wellman Psychology & Associates, S.C.
Psychology Group Practice
Assessment, Psychotherapy, and Consultation
3660 N. Lake Shore Drive, Suite 201
Chicago, IL 60613
(773) 683-1731
Fax: (773) 435-6354

A. APPLICANT INFORMATION

Last Name_____
First Name_____

If Recipient of Treatment or Evaluation is Different from Payee Please Provide the Following Information:

Client Last Name_____
First Name_____

B. PLEASE COMPLETE THE FOLLOWING INFORMATION IF YOU HAVE CHOSEN TO USE CREDIT/DEBIT CARD METHOD TO PAY FOR A CO-PAYMENT OR TOTAL COST OF SERVICES

BILLING INFORMATION

Name as it Appears on Credit/Debit Card_____

Mailing Address_____

City_____State_____ZIP_____Country___-_____

CREDIT/DEBIT CARD AUTHORIZATION

Circle one: Visa MasterCard Discover Card

__ __ __ __- __ __ __ __ - __ __ __ __ - __ __ __ __ __ __ / __ __ __ __ __
Credit/Debit Card Number Card Expiration Date Security Code

AMEX

__ __ __ __- __ __ __ __ __ __ - __ __ __ __ __ __ / __ __ __ __ __
Credit/Debit Card Number Card Expiration Date Security Code

I would like to receive a receipt by:

Email:_____

I authorize Dr. James D. Wellman Psy. D. or its authorized credit/debit card transaction agent(s) to bill my credit/debit card account indicated above for assessment, therapy or consultation.

Signature:_____ Date:_____

CREDIT OR DEBIT CARD PAYMENT AUTHORIZATION FORM