Cher L. King, Ph.D.
Licensed Psychologist

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Mailing Address
P. O. Box 102
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Card Information

Patient/Client name:	Name on card:
Type of card *(AMEX not accepted)*:	Card number:
Cardholder street address including city and zip code.	Expiration date: Security code:

Place your initials on the appropriate line below:

_____ *Use this card to process payment for all services as they are billed, without prior approval.*

_____ *Use this card to process a one-time payment in the amount of:* _____

Your signature certifies you are aware an additional 3% processing fee will be added to all charges to your card and you give your consent for this fee to be added.

_____ _____
Cardholder signature *Date signed*

This form may be mailed to the post office box listed above or emailed to Dr. King. You may wish to fill out the form, sign it, and mail it without filling in the credit card number, expiration date, and security code. You will be called so you can provide the number over the phone.

Enter your phone number: _____