



Crystal J. Fitzpatrick, PhD, APN, CARN-AP, MEd
39 Tamarack Circle, Skillman, NJ 08558-2019
(908) 419-8931 • fax (908) 636-2574
cjfitz14@aol.com
http://FitzpatrickConsultation.com

CREDIT CARD REGISTRATION FORM

In the event that a payment is not made at the end of a session, or that you do not show up for your scheduled appointment without cancelling in advance as stipulated in the missed/cancelled appointment policy, we will use the credit card information provided by you below to process the payment/fee for the session. Payment receipt and the statement of services rendered will be mailed to you at the address which was provided by you in the chart. It is your responsibility to update your mailing address if and when there is a change.

By providing your credit card information and signature, you are agreeing to use your credit card of your choice as a payment option and are consenting to all payment responsibilities to the credit card issuing bank. On your monthly statement, the charge will show up as "Fitzpatrick Consultation." There are no additional charges for using your credit card. However, it is the responsibility of the client to make sure the date of expiration on our file is up-to-date. If there are any questions, concerns or comments, please feel free to call (908) 419-8931.

Please print/write legibly.

Name of Client: _____

Credit card type (please check one): Visa MasterCard American Express Discover

Name on the Card: _____

Credit Card No: _____

Date of expiration: _____ / _____

CVV2: _____

(4 digit # in front for AmEx and 3 digit # on the back for visa/MasterCard/Discover card)

Billing address: _____

Street

City/Town

State

Zip

Signature: _____ Date signed: _____