

**JANEEN LOCKER, Ph.D., A PSYCHOLOGY CORPORATION  
CLINICAL PSYCHOLOGIST PSY 17889  
3101 OCEAN PARK BLVD., STE. 304  
SANTA MONICA, CA 90405**

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**CREDIT CARD CONSENT & AUTHORIZATION FORM**

I, \_\_\_\_\_, hereby authorize Janeen Locker, Ph.D. to keep my signature on file and to automatically charge my credit card account as indicated below:

for charges for missed or cancelled sessions, with less than 24 hours advance notice from \_\_\_\_/\_\_\_\_/\_\_\_\_ until Patient (named below) is formally discharged as a patient from the office of Janeen Locker, Ph.D. unless I revoke such authorization in writing beforehand.

for the amount of each check that does not clear the bank, for whatever reason, plus a \$20 returned check charge per incident.

**Optional:**

for a single charge of \_\_\_\_\_ for Patient's initial consultation on \_\_\_\_/\_\_\_\_/\_\_\_\_.

for recurring charges (ongoing treatments) per visit of \_\_\_\_\_ from \_\_\_\_/\_\_\_\_/\_\_\_\_ until Patient is formally discharged as a patient from the office of Janeen Locker, Ph.D. unless I revoke such authorization in writing beforehand.

**CHECK ONE:**

- MasterCard V code (3 digits in back): \_\_\_\_\_  
 Visa V code (3 digits in back): \_\_\_\_\_  
 American Express V code (4 digits in front): \_\_\_\_\_

A photocopy or facsimile of this signature is as valid as the original.

**PATIENT NAME:** \_\_\_\_\_

**CARDHOLDER NAME** (As printed on card): \_\_\_\_\_

**ACCOUNT NUMBER:** \_\_\_\_\_

**EXPIRATION DATE:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**CARDHOLDER BILLING ADDRESS:**

\_\_\_\_\_  
Street Number

\_\_\_\_\_  
Zip

**CARDHOLDER SIGNATURE:** \_\_\_\_\_ **DATE SIGNED:** \_\_\_\_/\_\_\_\_/\_\_\_\_