

BETHEL OLENTANGY PSYCHOLOGICAL SERVICES

An Association of Independent Practitioners

4949 Olentangy River Road

Columbus, OH 43214

Phone: (614) 451-6606

Fax: (614) 451-2923

Patient Name: _____

Clinician: _____

I, _____, agree to the use of the credit card number
(listed below) in my name for fees/co-payments associated with appointments for the above-named client
at the office of Bethel Olentangy Psychological Services. I understand that I will be notified of any unusual
charges or fees before they are billed to my credit card, and that this agreement is binding until written
notice canceling the agreement is received by the office.

Credit Card Number				Expiration Date	CVV Code

Cardholder Signature

Date

Witness _____