

# Client Payment Consent Form



Patient Name \_\_\_\_\_  
*Print Last First Middle Initial*

Name on Card if different \_\_\_\_\_

I authorize **Melinda Carlisle, and Critical Path Counseling** to charge my credit card for professional services as follows:

*Initial*  
\_\_\_\_\_ Recurring charges beginning January 8th until Termination,  
not to exceed (circle one) \$ \_\_150\_\_ per individual session or \_\_\$450\_\_ per  
skills module.

Type of Card:  Visa,  MasterCard,

Expiration Date \_\_\_\_\_

Security Code \_\_\_\_\_

Credit Card Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_,

Card Holder's Billing Address for Credit Card Statements

\_\_\_\_\_  
*Street City State Zip*

Card Holder Signature \_\_\_\_\_, Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

*Charges will appear on your credit card statement as **CriticalPath Consulting.***

**CriticalPath Counseling**  
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