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Credit Card Authorization Form

By completing and signing this form, I give Jeremy H. Broussard, PhD, LPC permission to debit my account in the amount of (1) the allowable charges indicated by my insurance company (i.e., either copay or full payment, if insurance does not pay) for services rendered at the time of the session and/or (2) payment for missed appointments or late cancellations. This permission is for a single or recurring transaction only and does not provide authorization for any additional unrelated debits or credits to your account.

Please provide the following information:

Account Type: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> AMEX <input type="checkbox"/> Discover
Cardholder Name: _____
Account Number: _____
Zip Code Associated with Account: _____
Expiration Date: _____
CVV2 (3 digit number on back of Visa/MC, 4 digits on front of Amex): _____

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for outpatient psychotherapy services described above and is valid for one time use or recurring charges. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company, so long as the transaction corresponds to the terms indicated in this form.