



*Yvonne Fritz, Psy.D.*  
*Mojave Meadows*  
*Psychological Services*

Phone: 214-856-0262 (TX)  
702-514-0098 (NV)

Email: [yvonne.fritz@mmpsychlv.com](mailto:yvonne.fritz@mmpsychlv.com)  
Servicing clients in North and Central  
Texas and Southern Nevada

**Credit Card Authorization Form For Ongoing Therapy Sessions**

**PLEASE COMPLETE THIS AUTHORIZATION AND RETURN VIA EMAIL.**

All information will remain confidential.

I give Yvonne Fritz, Psy.D. permission to charge the following credit card, debit card, flexible spending card, or health savings account:

Applicable charges include all of the following (please initial each charge):

Counseling Sessions

Report/Paperwork Requests

Records

Requests Late Cancellation/No Show

Group Sessions

Please read the following:

I understand that this release is limited to what I have agreed to above. If I would like to change the card information in the future, I will need to alert my counselor.

I understand that should an account become overdrawn, I am responsible for any incurred fees.

I understand that all credit cards are subject to a \$3 convenience fee. I understand that this fee will be applied to each transaction on my card.

*\* If, for any reason, multiple "charges" are processed as one single transaction – e.g., accrued charges/past due balances, multiple family members paying for individual sessions in a lump sum payment – one (1) \$3 convenience fee would be applied for the transaction.*

I agree that I will pay for services in accordance with the issuing bank cardholder agreement.

I understand that this release is valid when I sign it, and that I may withdraw my consent to this release at any time, either verbally or in writing.

I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my bank or credit card company as long as the transactions correspond to the terms indicated in this authorization form. I acknowledge that credit card transactions could be linked to Protected Health Information.

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PROVIDER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_