

Credit Card Debit Request Form

Date: _____

I _____
Cardholder's Name

authorise Kate James to debit the nominated account below for
payment of consultations for _____

Client's Name

In accordance with the letter that I received prior to my initial consultation and the practice guidelines, I also authorise Kate James to debit my account for a cancellation or non-attendance fee, if applicable.

Card Details

Name on Card: _____

Card Number: _____ (CCV):

Card Type : Visa Mastercard _____

(American Express Not Accepted)

Expiry Date: _____

Signed: _____

Central Psychotherapy

Unit 4, 6-10 Douro Place, West Perth 6005

Telephone: 0458620032 Email: kate@centralpsych.com.au website: www.centralpsych.com.au

Medicare details and consent for release of information

Do you consent to the release of medical and/or psychological information relevant to your case? Please circle Yes No

Medicare number: _____

Reference number: _____

Expiry: _____

Please note: Please ensure that you have provided your bank account details to Medicare so that your rebate can be processed.

Signed: _____ Date: _____

Name: _____



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