Leah M. Lagos, Psy. D, B.C.B.
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ELECTRONIC PAYMENT INFORMATION

Dr Lagos' office will issue you with an invoice for fees incurred. Payments can be made by credit card, check or bank wire transfer (instructions upon request) Please note, if you pay by credit card, a 3% fee will be applied with each transaction. Dr. Lagos accepts **Visa, MasterCard,** and **Discover**. This information will be securely stored in your clinical file and may be updated upon request at any time. Please be aware that transactions will appear as "Leah Lagos, LLC" on your bank or credit card statement.

For the avoidance of any doubt, Dr Lagos would like to clarify that her contract is directly with the patient and not with any insurance provider. The fees payable are ultimately the responsibility of the patient and Dr Lagos will not become involved in correspondence with insurance providers regarding payment of fees.

Client Name: ______________________________ Date of Birth: ___________________________

Address: ____________________________ City: ____________________State: ______ Zip: ________

Home Phone: ____________________________ Email: ____

Credit/Debit Card Information: (circle one): Visa MasterCard Discover

Card Number: ____

Expiration Date: __________________ CVC Code: ______________________

Account Holder Information:

Please indicate the name and address associated with the credit card account you wish to use.

Name: ____

Address: __________________________________ City: _______________________________

State: _______ Email: ________________ Zip Code:___________________________

My signature authorizes Dr. Lagos to charge my credit card for balances due.

__________________________________ ___________________

(Client or Legal Guardian Signature) **(Date)**