

**ANDREA BERNARD, PH.D.**  
**Licensed Psychologist**  
**PSY 13143**  
**2011 Palomar Airport Rd., #205**  
**Carlsbad, CA 92011**

---

**Tel/Text.: 760.815.8682**

**PAYMENT CONSENT**

I, \_\_\_\_\_ (PRINT NAME), hereby grant my consent that Andrea Bernard, Ph.D., use my credit card on file to charge for services related to my/my minor child's psychological treatment with her (including deductible, co-payments, co-shares, and missed or late-cancelled appointments), as agreed in the Office Policies and Information agreement that I signed at the onset of treatment with Dr. Bernard.

Please enter your payment information below:  
(This information will be kept safe and confidential)

\_\_\_\_\_  
Credit card number

\_\_\_\_\_  
Name on card

\_\_\_\_\_  
Exp. date

\_\_\_\_\_  
CVV #

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date