Kranz Psychological Services, PLLC

Evaluations – Counseling – ABA – Medication Management

2026 PAYMENT AUTHORIZATION FORM

KPS requires a credit card to be on file. Your signature below indicates that you understand and agree that this payment authorization form allows KPS to utilize any payment method on file without any additional information/notification in order to pay for the following (please initial):

_____Copays/Co-Insurance for counseling, evaluations, medication management sessions

_____Balances due for counseling, evaluations, and medication management

_____Late cancellation and no show fees

Payment Method Details:

Name on Card: _____

Card Number: _____

Card Expiration Date: _____

Security Code: _____

Billing Address: _____

Billing City/State: _____

Billing Zip Code: _____

Agreement and Signature:

I have read, understood, and accept the policies and procedures and conditions outlined in the Kranz Psychological Services "Practice Policies" regarding financial considerations. If the client is a minor, the signature below indicates I am the parent/legal guardian of the child and have managing conservatorship. A copy of this agreement/policies will be given to you if you desire, with the original placed in your file at Kranz Psychological Services, PLLC.

_____

Client Name

_____ _____

Client Signature OR Parent/Guardian Signature (if client is a minor) Date