Authorization to Bill Credit Card

Client Name:____

Service Provided: Counseling/Therapy

Dates of Service: _______ ________ ________ __________ _________

__________ _________ _________ ________ __________ _________

Payment Amount: ____________

Name as it appears on credit card: ____

Credit card Number:____

Expiration Date: ______/______ Security code:_________

Billing Address:

____

____

____

Email:_____________________________________

Telephone number:_________________________

I, ____, give Senovia Ross, LMFT authorization to charge my credit card for services provided. I understand this form will be kept on file for billing purposes only.

Print Name

____

Signature

____